HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

7 February 2013

at 9.00 a.m.

**in the Council Chamber,
Civic Centre, Hartlepool.**

MEMBERS: HEALTH SCRUTINY FORUM:

Councillors S Akers-Belcher, Brash, Fisher, Hall, Hargreaves, G Lilley and Wells.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. TO CONFIRM THE MINUTES OF THE MEETING HELD ON 10 JANUARY 2013

4. RESPONSES FROM LOCAL NHS BODIES, THE COUNCIL, EXECUTIVE OR COMMITTEES OF THE COUNCIL TO FINAL REPORTS OF THIS FORUM

4.1 NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group' s response to the investigation into 'Cancer Awareness and Early Diagnosis' – *Chief Officer Designate NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group / Director of Public Health*

5. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA SCRUTINY CO-ORDINATING COMMITTEE**

No items.

6. **CONSIDERATION OF PROGRESS REPORTS / BUDGET AND POLICY FRAMEWORK DOCUMENTS**

6.1 Health and Wellbeing Strategy – *Director of Public Health*

6.2 Briefing Report and Immunisation Strategy – *Director of Public Health*

7. **ITEMS FOR DISCUSSION**

Health Reforms

7.1 Health Reforms:-

(a) Covering Report - *Scrutiny Support Officer*

(b) Presentation - *Chief Officer Designate NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Director of Operations and Delivery - Durham, Darlington And Tees Area Team*

111 Number

7.2 Rollout of NHS 111 - Briefing Report – *Representatives from NHS Tees*

NTHFT Quality Account

7.3 North Tees and Hartlepool NHS Foundation Trust – Quality Account 2013/14:-

(a) Covering Report – *Scrutiny Support Officer*

(b) Presentation – Assistant *Director of Nursing and Patient Safety, North Tees and Hartlepool NHS Foundation Trust.*

Investigation into the JSNA Topic of Sexual Health

7.4 APAUSE AND C-Card – *Director of Public Health*

7.5 Written Evidence from St Hild's Church of England School

7.6 Formulate a view in relation to the needs of Hartlepool residents, the current level and quality of service provision to meet those needs and formulation of recommendations – *Members of the Forum*

Feedback Report – Bournemouth Borough Council

7.7 Feedback Report: Visit to Bournemouth Borough Council – *Chair of the Health Scrutiny Forum*

Six Monthly Monitoring report

7.8 Six Monthly Monitoring of Agreed Health Scrutiny Forum's Recommendations - *Scrutiny Support Officer*

NEAS Quality Account

7.9 North East Ambulance Services (NEAS) - *Scrutiny Support Officer*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

8.1 Forward Plan – *Scrutiny Support Officer*

9. **MINUTES FROM THE RECENT MEETING OF THE SHADOW HEALTH AND WELLBEING BOARD**

9.1 Minutes of the meeting held on 10 December 2012

10. **MINUTES FROM RECENT MEETING OF TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE**

10.1 Minutes of the meeting held on 7 January 2013

11. **REGIONAL HEALTH SCRUTINY UPDATE**

No items.

12. **ANY OTHER ITEMS WHICH THE CHAIRMAN CONSIDERS ARE URGENT**

FOR INFORMATION:

Date of Next Meeting – 7 March 2013, 9am in Council Chamber, Civic Centre, Hartlepool

HEALTH SCRUTINY FORUM

MINUTES

10 January 2013

The meeting commenced at 9.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Stephen Akers-Belcher (In the Chair)

Councillors: Keith Fisher, Ged Hall, Pamela Hargreaves, Geoff Lilley and Ray Wells

Also Present: Councillor Alison Lilley

Ann Malcolm, Head Teacher, Manor College of Technology
Joanne Fairless, Hart Gables
Mike Kay, Teesside Positive Action
Sue Skelton, Youth Service
Kimberley Chambers and Jacqueline Chambers, Targeted Support
Teresa Driver, Wharton Trust
Barry Hockborn and Michelle Barry, Nacro
Julie Gillon, Chief Operating Officer/Deputy Chief Executive, North Tees and Hartlepool Foundation Trust
Dr Posmyk, Chair, Hartlepool and Stockton on Tees Clinical Commissioning Group
Chris Tulloch, Clinical Director, Orthopaedics, North Tees and Hartlepool NHS Foundation Trust
Rowena Dean, Linda Watson, David Emerton and Dr Suresh, North Tees and Hartlepool NHS Foundation Trust
Ali Wilson, Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group
Nicola Jones, NHS Tees

Officers: Louise Wallace, Director of Public Health
David Hunt, Strategy and Performance Officer
Andrew Facchini, Participation Worker
Beth Storey, Youth Work Manager
Deborah Gibbon, Health Improvement Practitioner
Imran Abul and Juliette Ward - Integrated Youth Support Service
Laura Stones, Scrutiny Support Officer
Denise Wimpenny, Principal Democratic Services Officer

99. Apologies for Absence

An apology for absence was submitted on behalf of Councillor Brash.

100. Declarations of Interest by Members

None

101. Minutes of the meeting held on 13 December 2012

Confirmed

102 . Responses from Local NHS Bodies, the Council, the Executive or Committees of the Council to Final Reports of this Forum

None

103. Consideration of request for scrutiny reviews referred via Scrutiny Co-ordinating Committee

None

104. Scrutiny Investigation into the JSNA Topic of Sexual Health – Service Provision, What People Say and Effective Intervention - Evidence from Local Schools, Community and Voluntary Groups and Youth Groups - Covering Report *(Scrutiny Support Officer/Representatives from the Voluntary and Community Sector and Youth Groups/Representatives from Local Schools)*

As part of the Forum's investigation into the JSNA topic of Sexual Health, the Forum was advised that representatives from the Public Health Team, Local Schools, Voluntary and Community Sector Groups and Youth Groups had been invited to the meeting to provide information in relation to the investigation.

The Scrutiny Support Officer referred Members to the JSNA entry for Sexual Health and feedback from the implementation of the recommendations of the Young Inspectors following their inspection of the sexual health service at the One Life Centre, details of which were attached as appendices to the report.

A representative from Hart Gables, who was in attendance at the meeting, outlined the services they currently provided which included recent support with drug and alcohol related issues and highlighted that they were keen to extend the current sexual health service provision and work more closely with

Teesside Positive Action. In terms of any services they could not provide, service users were signposted to other organisations.

A representative from Teesside Positive Action, who was in attendance, referred to the limited capacity for funding and the need to extend provision in as many venues as possible. In response to concerns raised by Members regarding the potential impact of funding reductions in this area, the representative advised that whilst clinical screening tests were available as required, there was no funding available in terms of prevention and awareness raising.

A representative from the Wharton Trust advised that sexual health advice and teenage pregnancy support was provided to the 13 plus age range. However, due to limited resources, support was limited.

In the discussion that followed Members debated the importance of sexual health advice and the potential reasons for the higher than average teenage pregnancy rates in the town. A query was raised as to the level of awareness raising in schools given the potential reduction in support and advice from youth facilities following closures in the town. The Head Teacher from Manor College of Technology, who was in attendance as a representative for local schools, stated that the number of groups providing sexual health advice in schools had reduced resulting in a reliance on teachers to bridge the gap and provide support and advice in this regard. A Member emphasised the importance of repeated sexual health education sessions in schools and raised concerns regarding the transfer of responsibility to teachers in relation to sexual health advice and support, the disadvantages of which were discussed at length. The Head Teacher provided details of a recent joint sexual health programme that had been delivered in schools, the benefits of which were outlined.

Reference was made to the success of the APAUSE Programme and disappointment was expressed as to why such a successful programme had been withdrawn. The Forum was advised that the programme had been withdrawn approximately 3 to 4 years ago and the reasons for withdrawal were cost/resource related, details of which were provided. Following further debate regarding the success of the programme, the Forum requested that further details of the programme be provided to a future meeting of the Forum with a view to examining what the programme entailed, how the programme worked and what needed to be done to return to a similar level of provision that had existed previously. The Forum requested that the information should include statistics and trends for the period of operation of the programme including budget information to enable the relevant success areas and comparators to be identified.

Further discussion ensued in relation to the type and level of educational information available, the various methods of accessing information and the Forum was keen to explore such data at a future meeting of the Forum.

The Youth Work Manager, who was also in attendance at the meeting, provided details of the services currently provided by the local authority youth

service which included sex and relationship education and support, clinical screening, pregnancy testing as well as advice regarding risk taking behaviour. It was highlighted that 361 young people had registered with the Youth Service that year.

Emphasis was placed upon the issue of training and the importance of sharing knowledge with the voluntary and community sectors. The Youth Service Manager referred to the "train the trainers" in relation to the c card scheme administered through Public Health. The Chair referred to the difficulties experienced by the voluntary sector in accessing training of this type. It was highlighted that feedback from participants in the training had indicated frustrations as a result of a lack of resources to utilise the skills that had been gained from the training. It was suggested that the issue of resources be further explored as well as the effectiveness of c-card training and how to make the best use of c-card trained staff.

With regard to communication arrangements, it was recommended that communication arrangements of all groups, including non-statutory youth groups should be explored with a view to gaining a better understanding of communication arrangement and improving working relationships.

A representative from Targeted Support, who was in attendance, reported that the Group provided sexual health 1-1 advice in the evening and also delivered a 6 week training course. The Forum was advised of the benefits of 1-1 provision and it was noted that the 6 week course was mainly an information session. The representative went on to share feedback with the Forum from some of the young people the Group had supported.

In response to a query in relation to whether the Youth Worker's considered support was reaching hard to reach groups and what could be done to support this, the Teesside Positive Action Representative indicated that the main target age group was 16 to 24 year olds. However, there was evidence to suggest that the age group from mid thirties onwards was high risk and should also be targeted. The Youth Service Manager added that a number of measures were in place to target hard to reach groups which included the detached mobile resource service and referrals from Social Care and schools.

The Head Teacher from Manor College of Technology raised concerns in relation to sexual emotional health issues of teenagers and commented that some young people were placing themselves in vulnerable situations. The importance of continuing to educate young people to alleviate risks to emotional health and wellbeing were emphasised. A query was raised as to how the local authority could help to support schools with sex and relationship education. In response, the Forum was advised of the importance of health professionals continuing to work with teachers and playing a much more active role in sex and relationship education in schools.

Recommended

That the information given and comments of the Forum be noted and discussions be used to assist the Forum in completing the Scrutiny investigation.

105. Teenage Pregnancy Performance Report (*Director of Public Health)*

The Director of Public Health had been invited to the meeting to inform the Forum on the current position in relation to the reduction of the under 18 conception rate. The report provided details of statistics relating to under 18 conception rates for the period 1999-2010, number of live births for the period January 2008 to September 2012 and estimates of young mothers for the period 2007 to 2009. Whilst it was recognised that Hartlepool had experienced significantly higher teenage conception rates than the rest of England, in 2010 Hartlepool achieved a rate of 55.5 per 1000 which demonstrated a 31.7% reduction over 10 years. In relation to the number of live births, there had been a year on year reduction in the number of live births to young women in Hartlepool, details of which were set out in the report.

Recommended

That the contents of the report, be noted.

106. Scrutiny Investigation into the JSNA Topic of Sexual Health – What Needs Might be Unmet, Additional Needs Assessment and Recommended Commissioning Priorities (*Director of Public Health)*

The Director of Public Health provided the Forum with a presentation in relation to sexual health which focussed on the following issues:-

<u>Unmet Needs</u>

- Dedicated sexual health services for young people
- School and college based sexual health services
- Increase access to rapid HIV testing
- Deliver of evidence based and age appropriate sex and relationship education

<u>What Additional Needs Assessment is Required</u>

- Undertake a local sexual health needs assessment
- Further analysis of STI data
- Utilise the Mosaic segmentation tool to:-
  - Determine optimum methods for communication about services
  - Target health promotion messages

Recommended Commissioning Priorities

- Maintain efforts to reduce teenage pregnancy
- Reduce sexually transmitted infections by increasing testing in high risk groups and maximising service contacts
- Increase uptake of HIV testing and reduce late HIV diagnosis
- Ensure young people have access to sexual health services that are appropriate to their needs
- Improve the quality and opportunities for sex and relationship and risk-taking behaviour education in schools and other settings.

Recommended

That the information given be noted and supported.

107. Scrutiny Investigation into the JSNA Topic of Sexual Health – Formulate a View in relation to the Needs of Hartlepool Residents, the Current Level and Quality of Service Provision to Meet those Needs and Formulation of Recommendations (*Members of the Forum)*

It was agreed that this item be deferred to a future meeting.

Recommended

That the report be deferred to a future meeting of the Forum.

108. Service Transformation/Transition to a New Hospital – Covering Report

Following a brief adjournment, the Scrutiny Support Officer indicated that representatives from North Tees and Hartlepool NHS Foundation Trust had been invited to the meeting to update the Forum on service transformation/the bigger picture, transition arrangements to a new hospital and plans for the Holdforth Road site up until the new hospital was built.

The Chair welcomed representatives from the Foundation Trust and CCG to the meeting.

The presentation made jointly by Ali Wilson, Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group and Julie Gillon, Chief Operating Officer/Deputy Chief Executive, North Tees and Hartlepool Foundation Trust provided the Scrutiny Forum with an update on the current position and progress towards a new hospital and focussed on the following:-

- Overview
- Key Drivers – Contextual Picture
- Strategic Aim
- Philosophy
- 3 Key Elements of Momentum
  - Transforming services
  - Primary and community care capital planning project
  - The Hospital capital planning project
- New Hospital
  - 3 bidders selected
  - 3 months of design discussions with clinical teams
  - further evaluation at which stage 2 bidders are selected
  - further design dialogue
  - Trust will announce preferred developer
  - Parallel competitive dialogue to identify a funder
- Transport
  - £10.7 million allocated to contribute to improving existing road network at Wynyard
  - responsibility for this is shared between local councils and other businesses who use this network
- Strategy – New Hospital
- Contextual Timescale and Progress
  - Hospital due to open in 2017
  - Sustainability of services during interim period
  - QIPP and efficiency drive
  - Service Transformation – clinical case for change
  - The bigger picture
- Clear and Credible Plan 2012-2017
- Clinical Services Strategy
  - Care at or close to home
  - Care at Health Centres/GP surgeries
  - Care in integrated care centre
  - Care in hospital
- Service Transformation
- Community Renaissance
  - What does it mean?
  - How will it be delivered:?
- Pathways Hospital Care
  CIAT – assessment of need, triage into appropriate pathway with care plan, active review and discharge pathway
- Operate on a Model of Quality, Financial and Operational Effectiveness and Performance
- Clinical Case for Change
- Quality Legacy Document
  - PCTs will be abolished from 1 April 2013
  - Existing functions separated
  - Quality handover document to ensure quality and safety not at risk
  - Quality profile
- Next Steps
  - Continuous engagement with stakeholders

- Uphold and deliver the vision to ensure transition to new hospital
- Quality review (NCAT) National Clinical Advisory Team

- Summary and Conclusion
  - Vision for the future remains the same
  - Patient outcomes more important than buildings
  - Service transformation is being driven nationally
  - Services cannot remain static in run up to new hospital

Following conclusion of the presentation, representatives responded to a number of questions raised by Members which included the following:-

- In response to concerns raised regarding the lack of information provided in relation to Plan B in the event that the proposals for a new hospital were not achieved, whilst acknowledging that discussions had taken place regarding a second option, the Chief Operating Officer/Deputy Chief Executive referred to discussions at previous meetings regarding service pathways, the need to improve services for the future and, during the transition period, irrespective of the outcome of the proposals for a new hospital.

- The Chair raised a number of concerns in relation to the level of detail provided in relation to transitional arrangements and transport links as well as the lack of assurances that sufficient funding was available to finance the new hospital proposals. Members were provided with assurances that this was the first stage of the consultation process and further details would be presented to the Forum as part of the formal consultation process in due course. In relation to funding, and given that the present business case had been developed some time ago, Members were advised that there was a need to ensure that the proposals were affordable hence the need for changes in services as the current level of service provision could no longer be sustained.

- In relation to transport concerns, Members were advised that the Trust would work with the public and local authorities to examine the transport plan to support patient pathways.

- With regard to the proposed transfer of services, clarification was sought in relation to when the timescales would be available. It was highlighted that tentative timescales had been agreed. It was envisaged that the National Clinical Advisory Team would present a report to the Trust in 4-6 weeks which would then be shared with key stakeholders. Consultation and formal engagement was likely to commence in April whereupon the formal options around service change would be presented.

- The Forum debated the various reasons for closure of the Accident and Emergency Unit at the Holdforth Road site and clarification was sought as to whether the decision was as a result of the inability to attract clinicians to the area or purely cost related. The Trust representative indicated that whilst the shortage of qualified clinicians was an issue nationally, in order to achieve effective outcomes

hospitals around the country needed to centralise services.

- Members and the public were keen to ensure that appropriate transport arrangements were in place for accessing future services, given the low level of car ownership in Hartlepool.

- During further debate, concerns were reiterated in relation to the proposed migration of hospital services in Hartlepool during the transitional period and attention was drawn to the PFI model of finance that had been discredited. Details of the implications of such finance arrangements were requested together with assurances that the cost of financing the new hospital would not impact on patient care.

- In conclusion, the Forum looked forward to receiving further information on the proposals as part of the formal consultation process.

The Chair thanked the representatives for their attendance.

Recommended

That the contents of the presentation and comments of Members be noted.

109. HIP Replacements – Covering Report (*Scrutiny Support Officer)*

Members were advised that representatives from the North Tees and Hartlepool NHS Foundation Trust had been invited to the meeting following concerns raised by the Forum on 18 October in relation to hip replacement surgery and the type of replacement hip utilised in some surgery.

The Clinical Director, Trauma and Orthopaedics delivered a presentation which provided details of the joint replacement service, participation rates in pre-operative questionnaires, hip replacement surgery pre-operative condition specific health scores, knee replacement surgery pre-operative condition specific health scores, symptom severity information, overall and specific health gain following hip replacement and knee replacement surgery.

In terms of hip replacement health gain, the Trust was showing significant lower overall health gain than the average across England. However, the Trust had shown a significant improvement for condition specific improvement for hip replacements. The Trust was not showing any concerns for its generic health gains following knee replacement and knee replacement outcomes were being consistently monitored. As a result of a review of notes for 17 cases, 13 showed definite improvement with regard to their hip replacement. A more detailed analysis of all the notes was currently being undertaken. However, no correlation between those recorded as deterioration of their hip compared to their general health.

In terms of revision and primary surgery, there had been 22 revisions and

139 primary operations. Of the 33 that had deteriorated, 9 of these were revisions.

A Member raised concerns regarding a patient who had required second revision surgery and a different surgeon had dealt with the case, details of which were provided. The importance of continuity of care was emphasised. A representative from the Trust agreed to take those comments on board.

Recommended

That the contents of the presentation and comments of Members, be noted.

110. Briefing Report on Patient Flows *(Representatives from Hartlepool and Stockton on Tees Clinical Commissioning Group)*

Members were advised that representatives from Hartlepool and Stockton on Tees Clinical Commissioning Group had been invited to the meeting to provide an update of the flow and number of attendances at the One Life Centre with respect to Urgent Care.

Details of attendances at the Minor Injuries Unit and Walk In Centre including the number of patients transferred from the Minor Injuries Unit to an Acute Trust were provided, for the period July to September 2012 as detailed in the report. Provision by Northern Doctors Out of Hours together with the North East Ambulance Service level of transfers from the One Life Hartlepool to North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust for the same period was also outlined.

The report had demonstrated that an effective Urgent Care Service was offered to the population of Hartlepool from all three services within One Life, attendances for Urgent Care were significant and patients were attending the correct services. Those patients transferring to an Acute Trust amount to 0.31% of overall activity indicating that patient's were attending the correct Urgent Care Services at the right time, first time.

In the discussion that followed and, in order to gain a better understanding of patient flows, the Forum requested further information in relation to patient flows at the Emergency Assessment Unit in the University Hospital of Hartlepool including how many were GP Referrals, Ambulance Referrals and any other ways of referral to the Unit. Members also requested, details of the number of Hartlepool residents who may have attended North Tees Accident and Emergency Unit as opposed to the One Life Centre in Hartlepool.

Recommended

That the contents of the report, be noted and further information be awaited.

111. Consideration of progress reports/budget and policy framework documents - Proposals for Inclusion in the Council Plan 2013/14 *(Child and Adult Services Departmental Management Team)*

The Strategy and Performance Officer introduced the report which provided the opportunity for the Health Scrutiny Forum to consider the proposals for inclusion in the 2013/14 Council Plan that fell under the remit of the Forum. The Director of Public Health gave a detailed and comprehensive presentation which provided the proposed outcomes and actions contained within the plan. The presentation highlighted the challenges faced by the Department and proposals on how to deal with those challenges.

Following the conclusion of the presentation a discussion ensued which included the following issues:-

(i) With regard to Outcome 14 relating to reducing harm caused by drugs and alcohol misuse, the Forum commented on how the economic downturn/depression was affecting people's mental health and wellbeing and expressed concerns around a foreseeable increase in people using drugs and alcohol as an 'escape' mechanism. The Forum was pleased to note that actions had been included within the overall Plan to address these issues. Members emphasised the importance of engagement with the Police and Crime Commissioner on drug and alcohol issues.

(ii) In relation to the transfer of Public Health functions into the Local Authority, whilst Members viewed this as a great opportunity, the challenges that the Local Authority could face if funding for Public Health was reduced were recognised.

Recommended

(i) That the proposed outcomes and actions for inclusion in the 2013/14 Council Plan, attached at Appendix A, be supported.
(ii) That the comments of the Forum and concerns of Members in relation to Outcome 14, as outlined above, be presented to Scrutiny Co-ordinating Committee on 18 January 2013.

112. Briefing Report and Immunisation Strategy *(Director of Public Health)*

Due to time constraints, it was suggested that this item be deferred to a future meeting of the Forum.

Recommended

That the report be deferred to a future meeting of the Forum.

113. Issues identified from the Forward Plan

None

114. Minutes from the Recent Meeting of the Shadow Health and Wellbeing Board

None

115. Minutes from the Recent Meeting of the Tees Valley Health Scrutiny Joint Committee held on 3 December 2012

The Vice-Chair of the Forum referred to his recent attendance at the Tees Valley Health Scrutiny Joint Committee when it was reported that only two local authorities had responded to a request for details of the number of front line health care staff who had received flue vaccinations. The Director of Public Health provided assurances that this was in hand.

116. Regional Health Scrutiny Update

None

117. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

118. Any Other Business – Police and Crime Commissioner attendance at Scrutiny Co-ordinating Committee

The Chair reported that the Police and Crime Commissioner would be attending the meeting of Scrutiny Co-ordinating Committee on 15 February to provide an update on progress in relation to the Police and Crime Plan. Members were encouraged to forward any questions to the Scrutiny Support Officer before 18 January 2013.

119. Any Other Business – Visit to James Cook Hospital

The Chair advised that there was an opportunity for two members of the Forum to visit James Cook Hospital on behalf of the Forum on Tuesday 29 January 2013 at 1.30 pm. It was envisaged that the visit would last approximately 2 hours. In response to a request for expressions of interest, Councillors Hall and G Lilley expressed an interest.

Recommended

That Councillors Hall and G Lilley be nominated to attend the visit to James Cook Hospital.

120. Any Other Business – Visit by Dr Pedley

Members were reminded of a forthcoming visit by Dr Pedley from the Freeman Hospital in Newcastle on Friday 25 January at 1.00 pm who had agreed to deliver a presentation in relation to the Cyber Cancer appeal to which all Members had been invited to attend.

The meeting concluded at 12.25 pm.

CHAIR

HEALTH SCRUTINY FORUM

7 February 2013

Report of: HARTLEPOOL AND STOCKTON-ON-TEES CLINICAL COMMISSIONING GROUP / DIRECTOR OF PUBLIC

Subject: HARTLEPOOL AND STOCKTON-ON-TEES CLINICAL COMMISSIONING BOARD'S RESPONSE – CANCER AWARENESS AND EARLY DIAGNOSIS

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1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide Members of the Health Scrutiny Forum with feedback on the recommendations from the investigation into Cancer Awareness and Early Diagnosis, which was reported to the Hartlepool and Stockton-on-Tees Clinical Commissioning Board (CCG Board) on 11 December 2012.

2. BACKGROUND INFORMATION

2.1 On 11 December 2012, the CCG Board considered the Final Report of the Health Scrutiny Forum into Cancer Awareness and Early Diagnosis. This report provides feedback following the CCG Board's consideration of, and decisions in relation to this Forum's recommendations.

2.2 Two of the recommendations, (c) and (d) fall under the remit of the Clinical Commissioning Group and were considered by the Board meeting on 11 December 2012.

2.3 Following on from this report, progress towards completion of the actions contained within the Action Plan will be monitored through Covalent; the Council's Performance Management System; with standardised six monthly monitoring reports to be presented to the Forum.

3. SCRUTINY RECOMMENDATIONS AND EXECUTIVE DECISION

3.1 Following consideration of the Final Report, the CCG Board agreed with the recommendations and actions in their entirety as detailed in **Table 1** overleaf:-

Table1

OVERVIEW AND SCRUTINY ENQUIRY ACTION PLAN

NAME OF FORUM: Health Scrutiny Forum

NAME OF SCRUTINY ENQUIRY: Cancer Awareness and Early Diagnosis

	RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION+	FINANCIAL / OTHER IMPLICATIONS	LEAD OFFICER	COMPLETION DATE*
(c)	That in relation to the issue surrounding whether there is a link between high risk industrial workers and the contraction of cancers through the ingestion of particulates, such as coal dust:- (i) The Public Health Directorate at NHS Tees carries out a literature research into the topic; and (ii) That in relation to recommendation c(i) this information is shared with the Health Scrutiny Forum.	A literature review will be undertaken on this issue and the result feedback to Health Scrutiny Forum.	None	Director of Public Health	December 2012

(d)	That NHS Hartlepool and the emerging Clinical Commissioning Group:- (i) Ensure that cancer screening levels are improved across GP Practices in Hartlepool; and (ii) Devise and share a strategy with the Health Scrutiny Forum for targeting cancer screening and awareness activity in the workplace / venues where residents gather socially; building on the good practice of those workplaces who employ nurses.	The Director of Public Health will ensure that the Hartlepool Clinical Commissioning Group is informed about levels of uptake across the various screening programmes and ensure actions are taken to promote uptake across all eligible populations. The Director of Public Health will write a strategy for increasing awareness of the importance of screening programmes. This strategy will focus on maximising opportunities within the local community and amongst employers. A key part of the strategy will be to engage occupational health departments.	None None	Director of Public Health Director of Public Health	December 2012 December 2012

4. RECOMMENDATIONS

4.1 That Members note the proposed actions detailed within the Action Plan and seek clarification on its content where felt appropriate.

BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Health Scrutiny Final Report into 'Cancer Awareness and Early Diagnosis' considered by Cabinet on 9 July 2012.

Health Scrutiny Forum

7 February 2013

Report of: Director of Public Health

Subject: SECOND CONSULTATION DRAFT OF THE JOINT HEALTH AND WELLBEING STRATEGY

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to present to the Health Scrutiny Forum the second draft of the joint Hartlepool Health and Wellbeing Strategy (JHWS) for comment as set out in Appendix A.

2. BACKGROUND

2.1 NHS reforms require the Local Authority with partner agencies including the NHS to develop a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment (JSNA). The final strategy must be adopted by April 2013. The strategy should focus on not only protecting the health of the population but improving it through a range of evidence based interventions.

3. CONSULTATION PROCESS TO DATE

3.1 The aims of the consultation process were to:

1. To consult stakeholders on the strategic aims and objectives to be set in the JHWS for Hartlepool;

2. To prioritise the strategic objectives to deliver the strategic aims for health and wellbeing in Hartlepool.

3.2 The consultation process was launched at the Face the Public Event in July 2012. A prioritisation exercise undertaken across a range of venues and an online survey which aimed to establish priorities across each of the proposed strategic objectives. The prioritisation exercise was undertaken across a range of venues which included libraries, children's centres, GP surgery waiting rooms and Youth Centres. Participants were given a notional £25 to spend across seven strategic themes, these being;

- Give every child best start in life
- Enable all children and young people to maximise capabilities
- Enable all adults to maximise capabilities
- Create fair employment and good work for all

- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places
- Strengthen the role and impact of ill health prevention

A total of 465 participants took part in the exercise. The feedback from this process was presented to Scrutiny Co-ordinating Committee on the 19th October 2012.

3.3 The Shadow Health and Wellbeing Board has also undertaken a prioritisation of the strategic objectives. This stage enabled prioritisation of the objectives according to a set of agreed criteria. A framework for prioritisation was discussed based on evidence of good practice at the Shadow Health and Wellbeing Board in November 2012. The framework covered a range of criteria e.g. evidence base, service user and public views, economic considerations and political considerations. Members of the Board took responsibility for reviewing the 7 Marmot policy areas and assimilating information from the Joint Strategic Needs Assessment, feedback from the public consultation and developed an action plan under each policy area. The action plan is appended to the second draft of the strategy.

3.4 Other key partnerships including the Clinical Commissioning Group and the Neighbourhood Forums have also discussed the 1st draft of the Health and Wellbeing Strategy and provided feedback to the Shadow Health and Wellbeing Board. Hartlepool LINK is due to discuss the draft strategy and provide feedback on the 7th February 2013.

3.5 Alongside the consultation process an Equality Impact Assessment has been completed on the draft Strategy and is included as Appendix B for information.

4. CONSIDERATIONS FOR THE HEALTH SCRUTINY FORUM

4.1 The second draft of the Health & Wellbeing Strategy for Hartlepool including the proposed Action Plan is set out in Appendix A and takes account of the consultation and prioritisation exercises noted above. The Health Scrutiny Forum is asked to consider the second draft and provide comments which will be fed through into the final draft of the Strategy which will be considered in March/April 2013.

5. NEXT STEPS - PROCESS AND TIMESCALES

5.1 The following timetable below outlines the next steps in final political approval of the Strategy.

Step 3 – Final consultation and endorsement. January – February 2012.		
Where	**Description**	**Date of Meeting**
Scrutiny Co-ordinating Committee	Second Draft for comment / endorsement	18th January 2013

Shadow Health & Wellbeing Board	Second Draft for comment/ endorsement	28 January 2013
Cabinet	Second Draft for comment / endorsement	4 February 2013
Health Scrutiny Forum	Second Draft for comment / endorsement	7 February 2013

Step 4 - Political Approval for Strategy. March – April 2013.		
Where	**Description**	**Date of Meeting**
Health Scrutiny Forum	Final Strategy for approval	7 March 2013
Scrutiny Co-ordinating Committee	Final Strategy for approval	8 March 2013
Shadow Health & Wellbeing Board	Final Strategy for approval	11 March 2013
Cabinet	Final Strategy for approval	2 April 2013
Council	Final Strategy for approval	11 April 2013

6. RECOMMENDATIONS

6.1 The Health Scrutiny Forum is asked to comment on the second draft of the Hartlepool Health and Wellbeing Strategy and Action Plan.

7. APPENDICES AVAILABLE ON REQUEST, IN THE MEMBERS LIBRARY AND ON-LINE

Appendix A - Draft Hartlepool Health and Wellbeing Strategy and Action Plan.
Appendix B - Equality Impact Assessment of Draft Health and Wellbeing Strategy.

8. BACKGROUND PAPERS

8.1 Report to SCC on 27th July 2012 regarding consultation process for Health and Well Being Strategy.

Report to SCC on 19th October 2012 regarding first draft of Health and well Being Strategy.

Report to HSF on 23rd August 2012 regarding consultation process for Health and Well Being Strategy.

Report to HSF on 18 October 2012 regarding first draft of Health and Well Being Strategy.

9. CONTACT OFFICER

Louise Wallace
Director of Public Health
4th Floor Civic Centre
Hartlepool Borough Council

DRAFT HARTLEPOOL JOINT HEALTH AND WELLBEING STRATEGY, 2013-18

Partnership organisations
To be added: Sign-up page with organisations' logos.

Foreword
To be added: To be written by the Health & Wellbeing Board Chair.

Executive Summary
To be added: Summary of Commissioning Intentions / Priorities.

1. Vision

Improve health and wellbeing and reduce health inequalities among the population of Hartlepool.

This will be achieved through integrated working, focusing on outcomes and improving efficiency.

2. Purpose

The Joint Health and Wellbeing Strategy (JHWS) is a high-level summary outlining how Hartlepool Borough Council, Hartlepool Clinical Commissioning Group and other key organisations will address the health and wellbeing needs of Hartlepool and help reduce health inequalities.

The Health and Social Care Act (2011) establishes Health and Wellbeing Boards ('Boards') as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment and Health and Wellbeing Strategy for their area[1]. The JHWS is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic, evidence-based, outcomes-focused commissioning and planning for Hartlepool[2].

3. The case for improving health and wellbeing in Hartlepool

Health in Hartlepool is generally improving. There has been a fall in early deaths from heart disease and stroke; and the rate of road injuries and deaths is better than the England average[3].

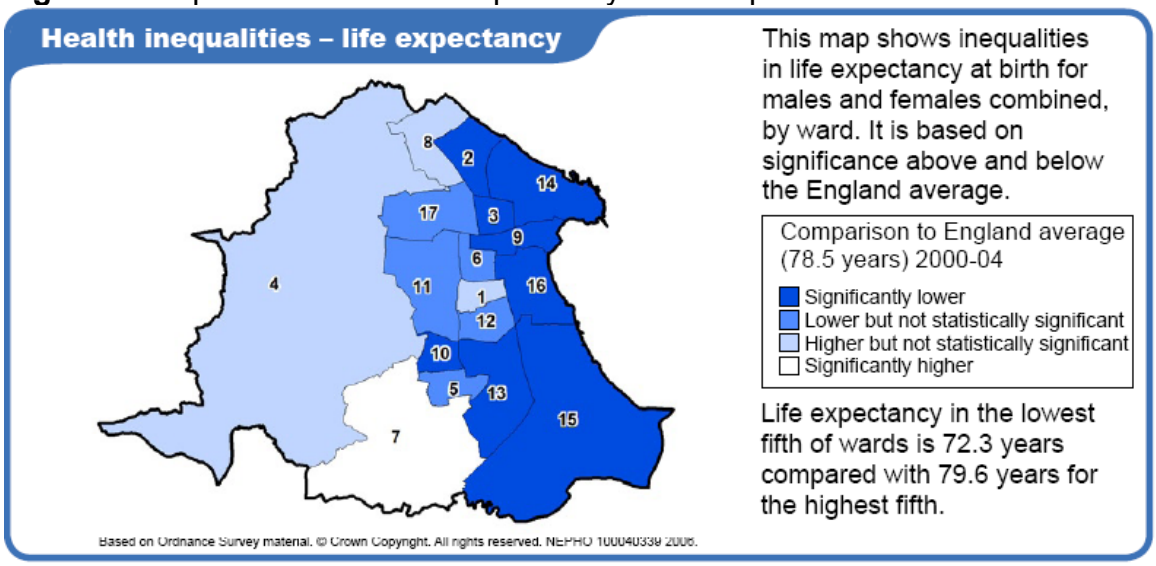
However, there is still much to do (**Box 1**). Health in Hartlepool is still worse than the national average. Levels of deprivation are higher and life expectancy is lower than the national average. **Figure 1** shows the variation in life expectancy

between wards in Hartlepool. This variation reflects the deprivation at ward-level: areas with the highest deprivation have the lowest life expectancy.

Box 1: At a glance: Health initiatives and challenges in Hartlepool[3]

- Levels of deprivation are higher and life expectancy is lower than the England average.
- Inequalities exist: life expectancy is 9 years lower for men living in the most deprived areas, compared to least deprived areas. The difference is 7 years for women.
- Over the last 10 years, the death rate from all causes has fallen for men but has fluctuated for women.
- The early death rate from cancer has changed little over the last 10 years.
- Both the death rate from smoking; and the percentage of mothers smoking in pregnancy are worse than the England average.
- The percentage of physically active children is better than the England average
- Alcohol-related hospital admissions are higher than the national average.
- Childhood immunisations rates are significantly lower than the national average.

Figure 1: Map of ward-level life expectancy in Hartlepool[3]



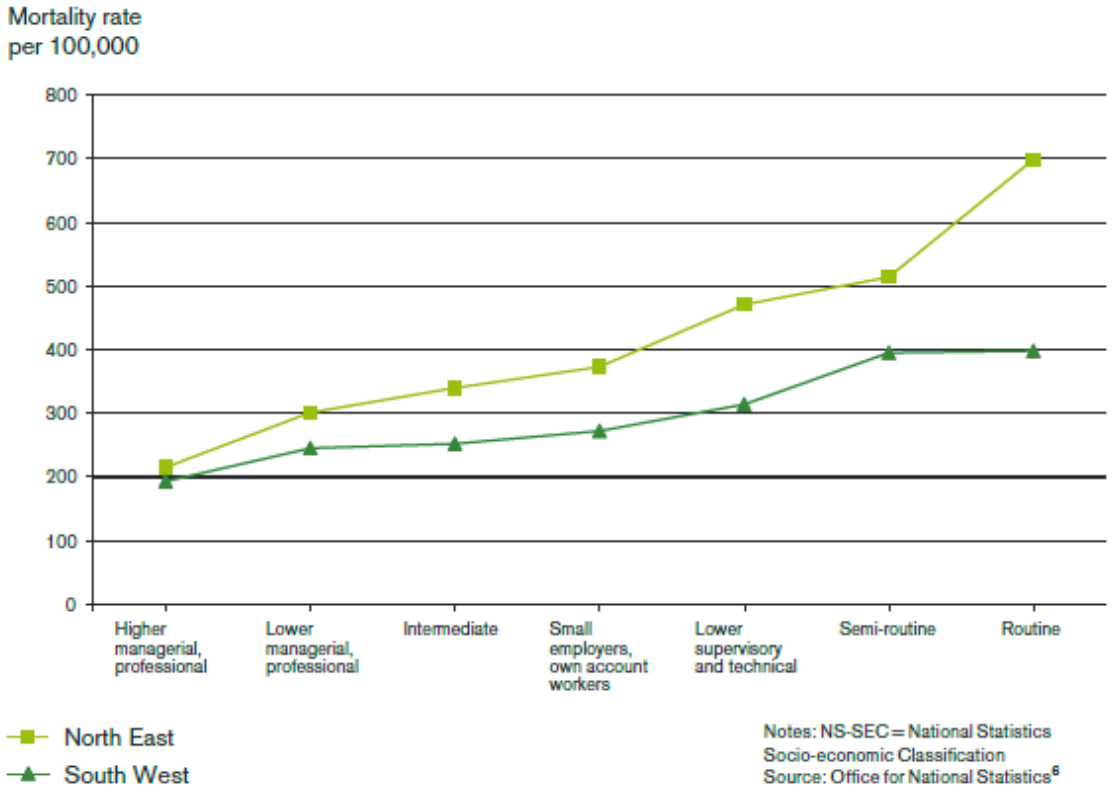
(Based on 2001 census data. Updated data for new ward boundaries should be available in 2013).

Ward legend

1	Brinkburn	7	Greatham	13	Rossmere
2	Brus	8	Hart	14	St. Hilda
3	Dyke House	9	Jackson	15	Seaton
4	Elwick	10	Owton	16	Stranton
5	Fens	11	Park	17	Throston
6	Grange	12	Rift House		

There is a 9 year difference in male life expectancy between the most advantaged and the most disadvantaged wards in Hartlepool[3,14]. We know that socio-economic inequalities lead to inequalities in life expectancy and disability-free life expectancy. Furthermore, the relationship between these is a finely graded – for every decrease in socio-economic conditions, both life expectancy and disability-free life expectancy drop. Social and economic inequalities are important causes of this relationship[4]. In his *Strategic Review of Health Inequalities in England* (2010)[4], Prof. Sir Michael Marmot argues that fair distribution of health, well-being and sustainability will impact positively on the country's economic growth. To improve health and wellbeing, action is needed across all social determinants of health to reduce health inequalities; and to make a difference, action to improve health and wellbeing should be across all socio-economic groups but tailored to a greater scale and intensity as the level of disadvantage increases[4]. As demonstrated in **Figure 2**, the effect of socioeconomic disadvantage on life expectancy is greater in more disadvantaged areas. However, the effect is also more pronounced in the North East compared to the South West, for all socioeconomic groups.

Figure 2: Age-standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25-64, 2001-2003[4]



We also know that focusing on early years interventions – giving children the best start in life – helps deliver the greatest benefits in health inequalities and

economic terms. Health and wellbeing improvements delivered during childhood can reap benefits both in early life and throughout the individual's life-course[4].

4. What does this Strategy cover?

This Strategy outlines the strategic health and wellbeing priorities for Hartlepool. It builds on the good work already underway, whilst maximising the opportunity for better integration of services and closer partnership working presented by moving much of current NHS Public Health services, into Local Authorities. Working together with other areas in the North East will help achieve better outcomes and value, for the 'big issues' in health and wellbeing[5]. The Strategy supports the ten themes of *Better Health, Fairer Health* (2008)[5,6] – the North East's vision and 25 year plan for improving Health and Wellbeing which is supported by other Local Authorities across the North East (**Box 2**).

Box 2: *Better Health, Fairer Health* (2008)[6]

- Economy, culture and environment
- Mental health, happiness and wellbeing
- Tobacco
- Obesity, diet and physical activity
- Alcohol
- Prevention, fair and early treatment
- Early life
- Mature and working life
- Later life
- A good death

'Health and Wellbeing' has a broad remit and it will be important for a range of partner organisations to work together, to deliver improvement. This Strategy focuses on areas of work impacting directly on health and wellbeing, or acting as clear 'wider determinants' of health and wellbeing. In his review[4], Prof. Sir Michael Marmot proposes the areas organisations should address to improve health and wellbeing and reduce health inequalities. These factors are used as the framework for the Hartlepool Joint Health and Wellbeing Strategy and are:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

To focus activity in these areas, key outcomes have been selected to drive the Strategy (Section 7).

Other elements of health and wellbeing (initially summarised by Dahlgren and Whitehead in their social model of health[7]) (**Appendix 2**) will be outside the direct remit and influence of the Health and Wellbeing Board and its partner organisations. They will be delivered through associated strategies and work programmes within Hartlepool Borough Council, the NHS and associated partners. Communication and governance processes will ensure links between departments and strategies to limit duplication, further build joint working and integration and enable economies of scale. The work programme underpinning the Strategy will define the activities needed to deliver the outcomes in the Strategy, and the partners responsible. The work will take place in the context of local service provision, including the Momentum project, which focusses on redesigning services and providing care closer to home.

5. Our Values

To work together successfully and achieve the vision set out in this Strategy, it is important that all organisations involved sign up to and work within, a set of shared values[8,9]. For Hartlepool, these values fit with the proposed operating principles for Boards[8] and the Board Terms of Reference. The values are:

- Partnership working and increased integration[2,8] across the NHS, social care and Public Health
- Focus on health and wellbeing outcomes
- Focus on prevention
- Focus on robust evidence of need and evidence of 'what works'
- Ensure the work encompasses and is embedded in the three 'domains' of Public Health practice: Health Protection, Health Services and Health Improvement[10]
- Shared decision-making and priority-setting, in consultation with CCGs and other key groups
- Maintain an oversight of and work within the budgets for health and wellbeing
- Support joint commissioning and pooled budget arrangements, where all parties agree this makes sense
- Maximise the process of democratic accountability and develop the Strategy and related plans in consultation with the public and service users

The new Health and Wellbeing Board and Joint Health and Wellbeing Strategy provide the opportunity to maximise partnerships and evidence base, generating new ways of tackling health and wellbeing challenges. This includes recognising and mobilising the talents, skills and assets of local communities to maximise health and wellbeing[11].

6. Identifying our key outcomes

The Strategy's key outcomes and objectives have been developed in consultation with stakeholders and with the following in mind:

- Services Hartlepool Borough Council will be mandated to provide from April 2013[12]

The services are listed in **Appendix 2**.

- Clinical Commissioning Group draft plans

The Strategy has been developed in close liaison with the Clinical Commissioning Group for Hartlepool and Stockton-on-Tees, whose draft Clear and Credible plan[13] has highlighted key challenges: cardiovascular disease; cancer; smoking –related illness e.g. COPD; alcohol-related disease. These areas reflect the results of a 2010 public engagement campaign, which recorded the views of 1883 people regarding priorities for them and their families. See **Appendix 3** for an overview of the draft CCG commissioning plan.

- Current JSNA commissioning intentions

The 2010 Hartlepool JSNA[14] (currently being refreshed through engaging key partners) outlines commissioning intentions for health and social care.

- Hartlepool Public Health Transition Plan

The transition plan outlines the proposed activity to be funded through the Public Health budget (**Appendix 4**).

<u>Stakeholder engagement and consultation</u>

It is very important that this Strategy reflects both the evidence available about population health and wellbeing need; and the views and priorities of stakeholders. Stakeholders have been involved throughout the development of the Strategy, including the public, service users and partner organisations. The Shadow Health and Wellbeing Board membership which owns the Strategy includes LINkS representation, democratically elected members, NHS organisations and Local Authority representation. A full consultation process provided the opportunity to identify the public's priorities for health and wellbeing in Hartlepool; and the outcomes of the consultation have been reflected in the priorities for the Strategy. The consultation process and a summary of its outcomes is outlined in **Appendix 5**. The consultation generated a list of potential priorities, from which a list of strategy priorities was agreed by the Health and Wellbeing Board, according to a set of robust criteria. The criteria included issues such as evidence base, public opinion, effectiveness and cost effectiveness (**Appendix 6**) and ensure the decisions were based on a clear and auditable process which balanced all key considerations.

7. Key strategic priorities and objectives

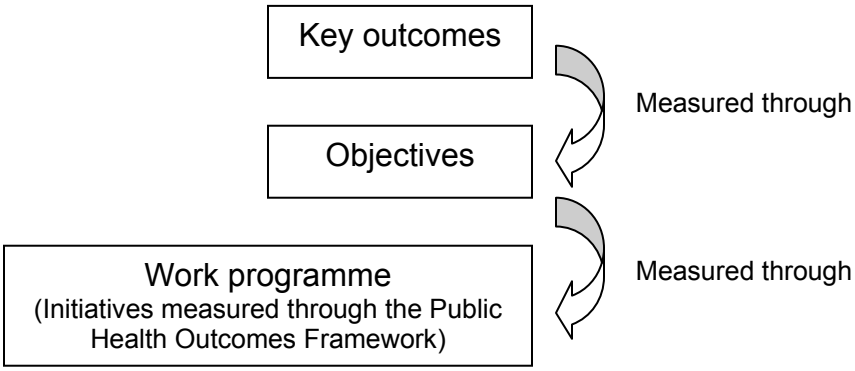
To reflect the consultation outcomes, evidence and subsequent prioritisation process, the key strategic priorities are:

Strategic priorities

- Give every child the best start in life
- Ensure a healthy standard of living for all
- Create fair employment

The evidence base and level of need for each are summarised in **Appendix 7**. To describe how the key priorities will be addressed, a range of objectives have been identified through the consultation process. Delivery on the objectives will be ensured through the work programme which supports this Strategy. The work programme specifies the detailed initiatives to deliver on the objectives and will also ensure coverage of the outcomes expected in the new Public Health Outcomes Framework[15]. **Figure 2** summarises the mechanism for ensuring delivery on the key outcomes.

Figure 2: Delivering on the key outcomes



Due to the broad nature of health and wellbeing, improvements will only be seen if the health and wellbeing agenda is also embedded in wider relevant Local Authority strategies and services. The work programme (**Appendix 8**) outlines how this is being done and **Appendix 9** shows how the Strategy and work programme are linked to theme groups under the Health and Wellbeing Board.

The objectives show how the Health and Wellbeing Board for Hartlepool will deliver on its key strategic priorities, and meet the challenge set out by Marmot's suggested priority area. The objectives are:

Outcome 1: Give every child the best start in life	
Objective A	Reduce child poverty
Objective B	Deliver early intervention strategy
Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives	
Objective A	Children and young people are empowered to make positive choices about their lives
Outcome 3: Enable all adults to maximise their capabilities and have control over their lives	
Objective A	Adults with health and social care needs are supported to maintain maximum independence.
Objective B	Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.
Objective C	Meet Specific Housing Needs
Outcome 4: Create fair employment and good work for all	
Objective A	To improve business growth and business infrastructure and enhance a culture of entrepreneurship
Objective B	To increase employment and skills levels and develop a competitive workforce that meets the demands of employers and the economy
Outcome 5: Ensure healthy standard of living for all	
Objective A	Address the implications of Welfare Reform
Objective B	Mitigate against the impact of poverty and unemployment in the town
Outcome 6: Create and develop healthy and sustainable places and communities	
Objective A	Deliver new homes and improve existing homes, contributing to Sustainable Communities
Objective B	Create confident, cohesive and safe communities
Objective C	Local people have a greater influence over local decision making and delivery of services
Objective D	Prepare for the impacts of climate change and takes action to mitigate the effects
Objective E	Ensure safer and healthier travel
Outcome 7: Strengthen the role and impact of ill health prevention	
Objective A	Reduce the numbers of people living with preventable ill health and people dying prematurely
Objective B	Narrow the gap of health inequalities between communities in Hartlepool

8. Strategy ownership and review

This Strategy is owned by the Shadow Health and Wellbeing Board. It will be reviewed by the Board on a 3-yearly basis.

Next review date: April 2013.

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1. Local Government Improvement and Development (April 2011) Joint Strategic Needs Assessment: A springboard for action. Available from: http://www.idea.gov.uk/idk/core/page.do?pageId=26995274

2. Nick Goodwin and Judith Smith for The King's Fund / Nuffield Trust (2011) Developing a nation strategy for the promotion of integrated care: The evidence base for integrated care. Slide pack available from: http://www.nuffieldtrust.org.uk/our-work/projects/developing-national-strategy-promotion-integrated-care

3. Department of Health / Association of Public Health Observatories (2006) Health Profile for Hartlepool 2006. Available from: http://www.apho.org.uk/resource/item.aspx?RID=50770

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7. Dahlgren G., Whitehead M. (1998) Health Inequalities. London HMSO

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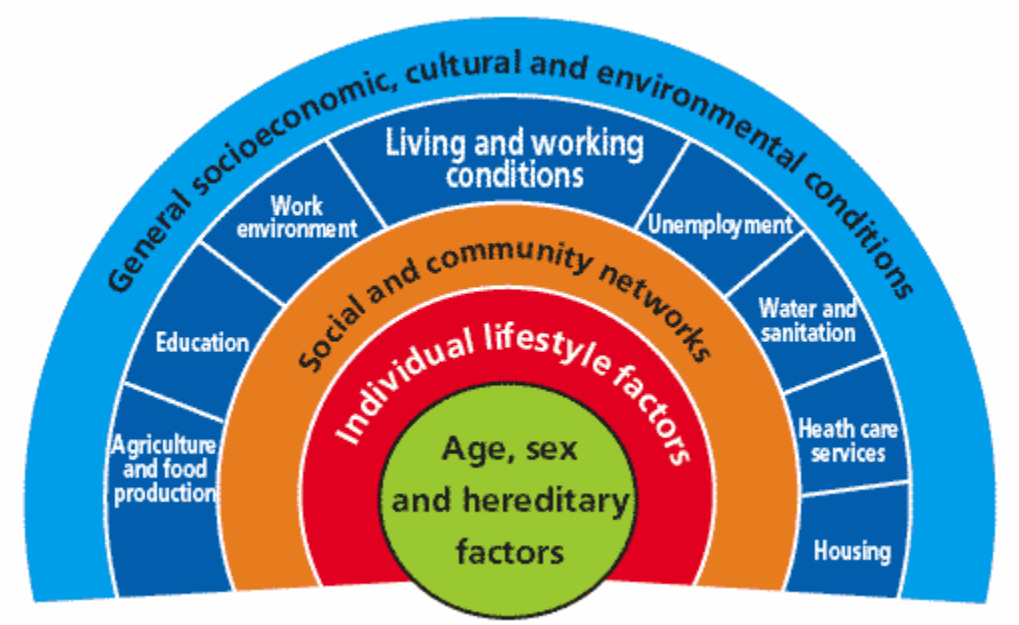
14. Hartlepool Borough Council / NHS Hartlepool (2010) Hartlepool Joint Strategic Needs Assessment. Available from: http://www.teespublichealth.nhs.uk/Download/Public/1012/DOCUMENT/9574/Hartlepool%20JSNA%202010%20Reference.pdf

15. Department of Health (2012) Healthy lives, healthy people: Improving outcomes and supporting transparency. A public health outcomes framework for England, 2013-2016. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

16. Child and Maternal Health Observatory (March, 2012) Child health profile: Hartlepool. Available from www.chimat.org.uk

Appendices

Appendix 1: Social model of health (Dahlgren and Whitehead, 1998)[7]



Appendix 2:

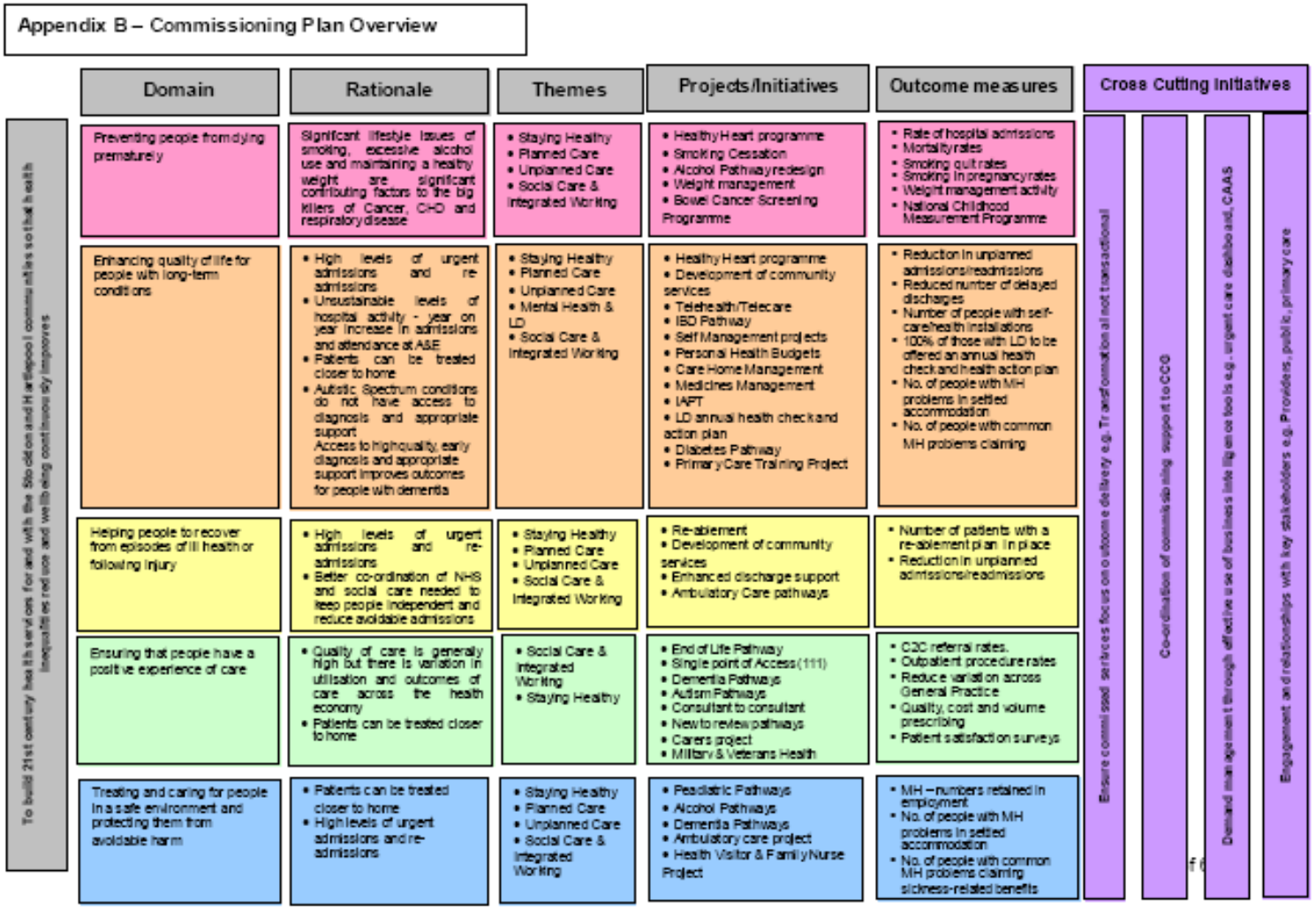
Local Authority mandated services[12]

Under the coalition government's proposals for the new Public Health system, Local Authorities will be mandated to provide the following from April 2013:

- Appropriate access to sexual health services
- Steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population
- Ensuring NHS commissioners receive the public health advice they need
- The National Child Measurement Programme
- NHS Health Check assessment

Consideration is also being given locally to the various additional services not covered by this list, which would be important to continue to provide e.g. stop smoking services.

Appendix 3: Hartlepool and Stockton-on-Tees draft CCG commissioning plan overview[13]



Appendix 4: Hartlepool Public Health Transition Plan: Proposed activity to be funded from the Public Health budget
NB: Subject to confirmation of the budgets available.

Public health topic	Proposed activity to be funded from Public Health budget
Sexual health	Testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and preventative work
Immunisation against infectious disease	School immunisation programmes, such as HPV.
Seasonal mortality	Local initiatives to reduce hospital admissions and seasonal excess deaths
Accidental injury prevention	Local initiatives such as falls prevention and reducing childhood injuries
Public mental health	Mental health promotion, mental illness prevention and suicide prevention
Nutrition	Locally led initiatives
Physical activity	Local programmes to reduce inactivity; influencing town planning such as the design of built environment and physical activities role in the management / prevention of long tram conditions
Obesity programmes	Local programmes to prevent and treat obesity, e.g. delivering the National Child Measurement programme; commissioning of weight management services
Drug misuse	Drug misuse services, prevention and treatment
Alcohol misuse	Alcohol misuse services, prevention and treatment
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and awareness campaigns
NHS Health check	Assessment and lifestyle interventions
Health at work	Local initiatives on workplace health and responsibility deal
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis
Children's public	The Healthy Child Programme for school age children, school nurses, health promotion and

health 5-19	prevention interventions by the multi professional team
Community safety and violence prevention and response	Specialist domestic violence services that provide counselling and support services for victims of violence including sexual violence
Social exclusion	Support for families with multiple problems, such as intensive family based interventions
Dental Public Health	Targeting oral health promotion strategies to those in greatest need.

Appendix 5: Consultation process for identifying objectives

The Strategy consultation ran from June – October 2012, in line with Local Authority consultation processes and statutory responsibilities. It consisted of:

A 'Face the Public' event
Approximately 70 people attended, representing a range of organisations from the community, voluntary and statutory sector and elected members.

A resource-allocation exercise
Set up in a range of venues including the shopping centre, the library, children's centres, GP surgeries and youth centres. The exercise asked members of the public to allocate £25 'virtual pounds' across the Marmot policy areas. 465 members of the public took part. 'Giving every child the best start in life' was the most popular priority amongst participants with almost 30% of the total budget allocated to this area.

When broken down by the type of venue, 'giving every child the best start in life' is the most popular priority across all venues, however this percentage is significantly less in the results obtained within libraries, where there was a more even spread across each priority area.

The next most popular was 'ensure a healthy standard of living for all' (16%).

An online survey
Open to the general public, the survey asked respondents to prioritise a range of suggested interventions listed under each Marmot policy area. Respondents were asked to choose the 3 most important issues under each Marmot area. They were:

- Give every child the best start in life – levels of child poverty (60%) and better parenting (62%). Next most popular: early years education (up to age 5) 25%
- Enable all children and young people to maximise their capabilities and have control over their lives – employment and training (60%), educational attainment (48%), aspirations of young people
- Enable all adults to maximise their capabilities and have control over their lives – employment and training opportunities (81%), aspiration levels (58%), educational attainment (57%)
- Create fair employment and good work for all – access to good jobs (78%), access to good quality training (52%), young people not in education or training (46%)
- Ensure a healthy standard of living for all – job opportunities (63%), having the level of income needed for leading a healthy life (55%), unemployment levels (43%)
- Create and develop healthy and sustainable places – levels of anti-social behaviour (53%), access to good quality housing for all (48%), good quality transport (37%)

- Strengthen the role and impact of ill health prevention – levels of obesity (62%), smoking levels (56%), alcohol intake (48%)

Free-text comments generally fitted with the areas of work that were presented as options for responders in the rest of the survey.

Consultation was also carried out with existing members of the LINkS. The draft Strategy was also shared with the CCG, through discussion at the CCG locality meeting, and through CCG membership on the Health and Wellbeing Board.

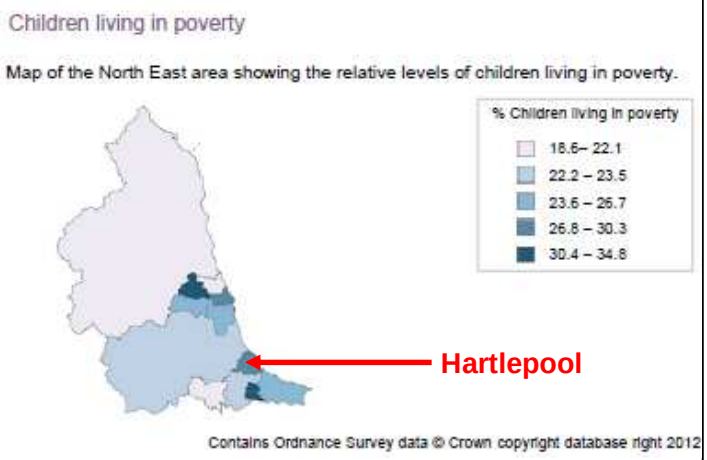
Appendix 6: Prioritisation criteria
To be added once agreed.

Appendix 7: Strategic priorities - Summary of evidence and need

Priority: Giving every child the best start in life

In Hartlepool:
(Sources: JSNA 2010[14], Health profile 2012[16])

- Immunisation: uptake of boosters e.g. 2nd MMR is 79%, compared to 91% uptake of first jab.
- 19% of women smoke in pregnancy compared to an England average of 14%.
- Breastfeeding initiation rate is approximately 42.2% in Hartlepool, compared to the England average of approximately 71.8%
- 13.8% of young people in Hartlepool have recorded substance misuse, compared to 9.8% for England
- Under-18 conception rates continue to fluctuate (59.7 per 1000 females aged 15-17, compared to the England average of 38.1 per 1000)
- The childhood obesity rate for Hartlepool is 22.8% compared to the England average of 18.3%
- 27.3% of Hartlepool children live in poverty
- Parenting and literacy skills: 30% of adults have low numeracy and 28% have literacy problems



(Source: Child Health Profile 2012[16])

Research shows

- Unimmunised children are at a far greater risk of contracting childhood illnesses such as measles, which can have serious health consequences.
- Smoking or exposure to smoke in pregnancy increases the risk of premature birth and low birth weight. Teenage mothers are much more likely to smoke during pregnancy.
- Babies who are breastfed have a reduced risk of illness in the short- and long-term.
- Educational attainment is directly linked to employment prospects. Better employment prospects are linked to better health and wellbeing outcomes.
- Alcohol misuse among parents can impact on children's health and wellbeing. Misuse among children is linked to other risk-taking behaviour e.g. teenage pregnancy. Alcohol admissions to hospital are increasing,
- Teenage pregnancy rates are higher than the national average. Babies born to teenage parents tend to have worse health and wellbeing outcomes. Some STI rates are also increasing.
- Increased confidence in parenting and family literacy skills impact positively on children's health, wellbeing and educational attainment.

What we plan to do

- Increase childhood immunisation rates
- Reduce smoking in pregnancy
- Increase breastfeeding
- Increase the number of young people who are 'work-ready' and increase appropriate employment opportunities
- Reduce the prevalence of alcohol misuse
- Provide sexual health services which are accessible to young people
- Promote parenting and family literacy skills

Priority: Ensure a healthy standard of living for all	
In Hartlepool: INSERT KEY FACTS	**ENTER PICTURE / GRAPH**

Research shows	**What we plan to do**

Priority: Create fair employment	
In Hartlepool: INSERT KEY FACTS	**ENTER PICTURE / GRAPH**

Research shows	**What we plan to do**

Appendix 8: Work programme
To be added.

A work programme will be defined to agree timescales and organisational accountability for contributing towards outcomes. This should include a risk log for the implementing the Strategy.

Appendix 9: Paper to show how the Strategy and work programme are linked to theme groups under the Health and Wellbeing Board
To be added.

Outcome 1: Give every child the best start in life	
Objective A	Reduce child poverty
Objective B	Deliver early intervention strategy
Outcome 2: Enable all children and young people to maximise their capabilities and have control over their lives	
Objective A	Children and young people are empowered to make positive choices about their lives
Outcome 3: Enable all adults to maximise their capabilities and have control over their lives	
Objective A	Adults with health and social care needs are supported to maintain maximum independence.
Objective B	Vulnerable adults are safeguarded and supported while having choice and control about how their outcomes are achieved.
Objective C	Meet Specific Housing Needs
Outcome 4: Create fair employment and good work for all	
Objective A	To improve business growth and business infrastructure and enhance a culture of entrepreneurship
Objective B	To increase employment and skills levels and develop a competitive workforce that meets the demands of employers and the economy
Outcome 5: Ensure healthy standard of living for all	
Objective A	Address the implications of Welfare Reform
Objective B	Mitigate against the impact of poverty and unemployment in the town
Outcome 6: Create and develop healthy and sustainable places and communities	
Objective A	Deliver new homes and improve existing homes, contributing to Sustainable Communities
Objective B	Create confident, cohesive and safe communities
Objective C	Local people have a greater influence over local decision making and delivery of services

Objective D	Prepare for the impacts of climate change and takes action to mitigate the effects
Objective E	Ensure safer and healthier travel
Outcome 7: Strengthen the role and impact of ill health prevention	
Objective A	Reduce the numbers of people living with preventable ill health and people dying prematurely
Objective B	Narrow the gap of health inequalities between communities in Hartlepool

**** Identifies Public Health Outcome Framework Indicators**

OUTCOME 1: GIVE EVERY CHILD THE BEST START IN LIFE

LEAD OFFICER: SALLY ROBINSON, ASSISTANT DIRECTOR (PREVENTION, SAFEGUARDING AND SPECIALIST SERVICES), HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Immunisation Strategy
- Breastfeeding Strategy
- Stop Smoking Maternal Action Plan
- Healthy Schools
- Teenage Pregnancy Strategy & Action Plan
- Children & Young People's Plan
- Child Poverty Strategy
- Clinical Commissioning Group Commissioning Plan
- Public Health Transition Plan
- Early Intervention Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Children's Strategic Partnership
- Teenage Pregnancy Strategy Group
- 'Be Healthy' Group
- Immunisation Strategy Group
- Child Poverty Strategy Group

OBJECTIVE A – REDUCE CHILD POVERY

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Children living in poverty	HMRC	Annually	No current target as government reviewing measurement
Proportion of children living in workless households	DWP	Annually	
Rate of family homelessness	DCLG	Annually	

REF.	ACTION	ASSIGNED TO	DUE DATE
	Ensure that children who live in poverty are safe	Sally Robinson	March 2015
	Increase the parental employment rate	Anthony Steinberg	March 2015
	Improve skill levels in parents and children	Danielle Swainston	March 2015
	Increase benefit take up rate including in work and out of work benefits	Danielle Swainston	March 2015
	Prevent those at risk falling into poverty	Danielle Swainston/John Robinson	March 2015
	Where it is evident that a family is experiencing poverty, take action to mitigate its effects	Danielle Swainston/John Robinson	March 2015

OBJECTIVE B – DELIVER EARLY INTERVENTION STRATEGY

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**School Readiness	TBC	TBC	TBC
**low birth weight of term babies	ONS	TBC	TBC
**Breastfeeding	TBC	TBC	TBC
**Smoking status at time of delivery	TBC	TBC	TBC
**Excess weight in 4-5 and 10-11 year olds	NCMP	TBC	TBC
Children achieving a good level of development at age 5	LA	Annual	
**Not in education, employment or training	LA	Annual	6.6%
**Teenage conception rate (age under 18 years)	DoH	Annual	
**Infant Mortality	ONS	Annual	Annual
**Tooth decay in children aged five years	TBC	4 Yearly	
GCSE achieved (5A*-C inc Eng and Maths)	LA	Annual	58%
Children defined as Child In Need	LA	Annual	

REF.	ACTION	ASSIGNED TO	DUE DATE
	Implement Early Intervention Strategy	Danielle Swainston	March 2015
	Embed common assessment as a means to identify and respond to need	Danielle Swainston	October 2013
	Provide a multi agency single point of contact for information, advice, guidance and access to services for children and their families	Danielle Swainston	March 2013
	Implement the Early Years Pathway delivering targeted support to children pre birth to five	John Robinson	September 2013

	Deliver an integrated 0-19 multi agency family support service for children who require support additional to that provided by universal services.	John Robinson	March 2013
	Provide integrated support for young people via the One Stop Shop	Mark Smith	March 2013

OUTCOME 2: ENABLE ALL CHILDREN AND YOUNG PEOPLE TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

LEAD OFFICER:

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Children's & Young people's Plan
- Child Poverty Strategy
- Public Health Transition Plan
- Stop Smoking Maternal Action Plan
- Teenage Pregnancy Strategy & Action Plan
- Carers Strategy
- Clinical Commissioning Group Community Plan
- Mental Health / CAM HS Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Children's Strategic Partnership
- Teenage Pregnancy Strategy Group
- Child Poverty Strategy Group
- North Tees, Hartlepool NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Health Foundation Trust
- NHS Hartlepool & Stockton-on-Tees CCG

OBJECTIVE A: CHILDREN AND YOUNG PEOPLE ARE EMPOWERED TO MAKE POSITIVE CHOICES ABOUT THEIR LIVES

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Pupil Absence	School Absence record	6 Monthly	TBC
**First time entrants into youth justice system	PNC	Annual	TBC
**Under 18 conceptions	ONS	Annual	TBC
**Child development at 2-2.5 years	TBC	TBC	TBC
**Percentage of 16 to 18 year olds who are Not in Education, Employment or Training (NEET)	HBC		
**Hospital admissions caused by unintentional and deliberate injuries in the under 18s	Hospital Episodes Stats	Annual	TBC
**Emotional wellbeing of looked-after children	HBC	Annual	TBC
**Smoking prevalence – 15 year olds	TBC		
**Hospital admissions as a result of self harm	Hospital Episode Stats	Annual	
Percentage gap between those young people from low income backgrounds and those that are not progressing to higher education	HBC	Annual	20%
Percentage of young people achieving a Level 2 qualification by the age of 19	HBC	Annual	78.5%
Percentage of young people achieving a Level 3 qualification by the age of 19	HBC	Annual	49.5%
Percentage gap in the achievement of a Level 3 qualification by the age of 19 between those claiming free schools meals at academic age 15 and those that were not	HBC	Annual	21%
Percentage of young people who were in receipt of free school meals at	HBC	Annual	21%

academic age 15 who attained Level 2 Qualifications by the age of 19			
Unplanned hospitalisation for asthma, diabetes & epilepsy in under 19's	CCG	Quarterly	TBC
Emergency Admissions for Children with lower respiratory tract infections	CCG	Quarterly	TBC
SEN children or those with disability with personal budgets and single assessment across health, social care & education	CCG, HBC, SCHOOLS	Quarterly	TBC
Employment rate (16-24) – proportion of 16-24 year olds who are in employment	NOMIS, HBC	Annual	2014 target 46.5%
% of 16-24 year olds who are not in education, employment or training (NEET)	Dept of Education, HBC	Annual	2014 target 6.5%
Youth unemployment rate – the proportion of occupationally active 18-24 year olds who are unemployed.	NOMIS, HBC	Annual	2014 target 14.5%

REF.	ACTION	ASSIGNED TO	DUE DATE
	Reduce the level of young people who are Not in Employment, Education or Training (NEET) by implementing NEET Strategy.		
	Provide support for vulnerable young people to enable them to be economically active.		
	Ensure access to high quality learning opportunities that increase the skills and qualifications of local residents via implementing the Adult Education Service Plan		
	Increase the take up of Apprenticeships by liaising with local employers to increase opportunities		
	Work collaboratively with LA & Schools to review and develop single assessment arrangements for children with SEN or disability	TBC	March 2014
	Develop plans to increase the number of SEN and disabled children with personal budgets	TBC	March 2014

	Develop plans to improve education and support to families and children/young people with chronic health conditions	TBC	March 2014

OUTCOME 3: ENABLE ALL ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

LEAD OFFICER: JILL HARRISON, ASSISTANT DIRECTOR (ADULT SOCIAL CARE), HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Vision for Adult Social Care in Hartlepool
- Carers Strategy
- Mental Health Strategy
- Housing, Care & Support Strategy
- Reablement Strategy
- Telecare Strategy
- Clinical Commissioning Group Commissioning Plan

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Learning Disabilities Partnership Board
- Safeguarding Vulnerable Adults Board
- Mental Health Consultation Group
- Carers Strategy Group
- Champions of Older Lifestyles Group
- Teesside Vulnerable Adults Board
- 50+ Forum
- Housing Care & Support Group
- Long Term Conditions Planning Group

OBJECTIVE A: ADULTS WITH HEALTH AND SOCIAL CARE NEEDS ARE SUPPORTED TO MAINTAIN MAXIMUM INDEPENNDENCE

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI125: Achieving independence for older people through rehabilitation / intermediate care.	HBC	Quarterly	TBC
NI131: Delayed transfers of care attributable to social care	HBC	Quarterly	TBC
NI135: Carers receiving needs assessment or review and a specific carers service or advice and information.	HBC	Quarterly	TBC
NI136: People supported to live independently through social services.			
P050: Access to equipment: percentage delivered within 7 days	HBC	Quarterly	TBC
P051: Access to equipment: users with telecare	HBC	Quarterly	TBC
P066: Admissions to residential care age 65+	HBC	Quarterly	TBC
Patients with a LOS<24hrs with an overnight stay NEL admissions via A&E NEL admissions via GP/Bed bureau A&E attendances ALOS (excl O LOS) ALOS for patients discharged to a different location to admitting location Delays to transfer of care (Bed days) Acute admissions from care homes Emergency readmissions within 30 days of discharge from hospital Emergency readmission rate within 30 days of discharge from hospital No of ambulatory care patients	CCG	Quarterly	TBC
NI125: Achieving independence for older people through	HBC	Quarterly	TBC

rehabilitation / intermediate care.			
NI131: Delayed transfers of care attributable to social care	HBC	Quarterly	TBC
NI135: Carers receiving needs assessment or review and a specific carers service or advice and information.	HBC	Quarterly	TBC
NI136: People supported to live independently through social services.			
P050: Access to equipment: percentage delivered within 7 days	HBC	Quarterly	TBC
P051: Access to equipment: users with telecare	HBC	Quarterly	TBC
P066: Admissions to residential care age 65+	HBC	Quarterly	TBC

REF.	ACTION	ASSIGNED TO	DUE DATE
	Further develop reablement services to meet the needs of all citizens (including people with dementia and disabilities) to prevent hospital and care home admissions or reduce ongoing dependency on health and social care services.	Phil Hornsby, HBC John Lovatt, HBC CCG NT&HFT TE&WV FT	March 2014
	Maximise the use of preventative approaches such as assistive technology to support people to maintain their independence.	Phil Hornsby, HBC CCG NT&HFT	March 2014
	Review services for carers to ensure that carers receive appropriate support to maintain their role, including access to short breaks.	Phil Hornsby, HBC CCG	March 2014
	Further develop reablement services to meet the needs of all citizens (including people with dementia and disabilities) to prevent hospital and care home admissions or reduce ongoing dependency on health and social care services.	Phil Hornsby, HBC John Lovatt, HBC CCG NT&HFT TE&WV FT	March 2014
	Maximise the use of preventative approaches such as assistive technology to support people to maintain their	Phil Hornsby, HBC CCG	March 2014

	independence.	NT&HFT	
	Review services for carers to ensure that carers receive appropriate support to maintain their role, including access to short breaks.	Phil Hornsby, HBC CCG	March 2014

OBJECTIVE B: VULNERABLE ADULTS ARE SAFEGAUREDED AND SUPPORTED WHILE HAVING CHOICE AND CONTROL ABOUT HOW THEIR OUTCOMES ARE ACHIEVED.

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI130b: Social care clients receiving self directed support	HBC	Monthly	TBC
NI145: Adults with learning disabilities in settled accommodation.	HBC	Monthly	TBC
NI146: Adults with learning disabilities in employment.	HBC	Monthly	TBC
NI149: Adults in contact with secondary mental health services in settled accommodation.	HBC / TE&WV FT	Monthly	TBC
NI150: Adults in contact with secondary mental health services in employment.	HBC / TE&WV FT	Monthly	TBC
NI130b: Social care clients receiving self directed support	HBC	Monthly	TBC
NI145: Adults with learning disabilities in settled accommodation.	HBC	Monthly	TBC
NI146: Adults with learning disabilities in employment.	HBC	Monthly	TBC
NI149: Adults in contact with secondary mental health services in settled accommodation.	HBC / TE&WV FT	Monthly	TBC
NI150: Adults in contact with secondary mental health services in employment.	HBC / TE&WV FT	Monthly	TBC
**People in prison who have a mental illness or significant mental illness	TBC	TBC	TBC
**Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness	Labour Force Survey	TBC	TBC

REF.	ACTION	ASSIGNED TO	DUE DATE
	Increase the number of people who direct their own care and support by accessing personal budgets and personal health budgets.	Geraldine Martin, HBC CCG	March 2014
	Further develop local arrangements to safeguard vulnerable adults ensuring continued engagement of all strategic partners and an appropriate and timely response to expected changes in legislation.	John Lovatt, HBC Funding partners – CCG and Cleveland Police All strategic partners	March 2014
	Increase the number of people who direct their own care and support by accessing personal budgets and personal health budgets.	Geraldine Martin, HBC CCG	March 2014
	Further develop local arrangements to safeguard vulnerable adults ensuring continued engagement of all strategic partners and an appropriate and timely response to expected changes in legislation.	John Lovatt, HBC Funding partners – CCG and Cleveland Police All strategic partners	March 2014

OBJECTIVE C: MEET SPECIFIC HOUSING NEEDS

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**People with learning disabilities in settled accommodation	Mental Health Minimum data set	Quarterly	
**People receiving secondary mental health services in settled accommodation	Mental Health Minimum data set	Quarterly	
**Statutory homelessness: Homelessness applications	HBC		
**Statutory homelessness: Households in temporary accommodation	HBC		

Average waiting time for a Disabled Facilities Grant to be completed	Time Monitoring Spreadsheet HBC	Quarterly	None – monitoring PI to reduce the time taken and set a baseline for future targets

REF.	ACTION	ASSIGNED TO	DUE DATE
HS3B2	Improve partnership working with health and social care in service planning and delivery for older people through the Housing Care and Support Strategy Steering Group	Housing Services Manager Nigel Johnson Head of Service (C&A) Phil Hornsby	March 2013
3B5	Monitor access to new and existing housing care and support schemes for people with disabilities	Head of Service (C&A) Neil Harrison	March 2015
3B9 (proposed replacement action)	Undertake a review of the current Housing Adaptations Policy and gather data to inform the new Policy and Implementation Plan.	Karen Kelly	December 2013
Proposed new action	Assist people to maintain independent living through the provision of minor adaptations.	Karen Kelly	March 2014
HS3B10	Increase the use of Assisted Technology by case finding as a preventative measure	All Registered Providers Head of Service (C&A) Phil Hornsby	March 2014

OUTCOME 4: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL
LEAD OFFICER: DAVE STUBBS, DIRECTOR OF REGENERATION & NEIGHBOURHOODS, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Economic Regeneration Strategy
- 14 - 19 Strategy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Economic Regeneration Forum

OBJECTIVE A: TO IMPROVE BUSINESS GROWTH AND BUSINESS INFRASTRUCTURE AND ENHANCE A CULTURE OF ENTREPRENEURSHIP

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Business stock (business units in Hartlepool)	Annual Business Register / NOMIS, HBC	Annual	2014 target of 2,400
Percentage of newly born enterprises surviving two years	Annual Business Register / NOMIS, HBC	Annual	2014 target of 77.4%
New business registration rate – the proportion of new business registration per 10,000 resident population	Annual Business Register / NOMIS, HBC	Annual	2014 target of 30

REF.	ACTION	ASSIGNED TO	DUE DATE
	Deliver Business Advice and Brokerage – Programme	Mick Emerson	March 2014

	of targeted account management with key businesses. Develop and maintain relationships with individual businesses.		
	Continued provision of Incubation support service including mentoring, pre-start support (Enterprise Coaching), financial assistance, brokerage and other initiatives.	Mick Emerson	March 2014
	Undertake 'Get Serious' awareness raising activities including marketing campaigns and events.	Mick Emerson	March 2014
	Engage with DWP Providers to offer unemployed individuals a wider package of support where appropriate to enter into self-employment.	Mick Emerson	March 2014

OBJECTIVE B: TO INCREASE EMPLOYMENT AND SKILL LEVELS AND DEVELOP A COMPETITIVE WORKFORCE THAT MEETS THE DEMANDS OF EMPLOYERS AND THE ECONOMY.

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Overall employment rate (proportion of people of working age population who are in employment)	Annual Population Survey, NOMIS, HBC	Annual	2014 target of 63%
Self-employment rate	NOMIS, HBC	Annual	2014 target of 9%
Employment rate (16-24) – proportion of 16-24 year olds who are in employment	NOMIS, HBC	Annual	2014 target of 46.5%
Percentage of 16 to 18 year olds who are in not in education, employment or training (NEET)	Department for Education, HBC	Annual	2014 target of 6.5%
Youth unemployment rate (Hartlepool) – The proportion of economically active 18 to 24 year olds	NOMIS, HBC	Annual	2014 target of 14.1%

who are unemployed			

REF.	ACTION	ASSIGNED TO	DUE DATE
36	Full implementation of the Raising Participation Age (RPA) Strategy	Mark Smith/Tom Argument	March 2014
38	Develop the 14-19 curriculum pathways in conjunction with employers from new industries and identified growth sector areas	Tom Argument	March 2014
39	Fully implement the 11-19 Operational Plan to raise education standards at key stage 4 and 5	Tom Argument	March 2014
49	Development of new partnership arrangements between Hartlepool Borough Council and the National Apprenticeship Service (NAS) to promote apprenticeship programmes to employers	Patrick Wilson	April 2013
N/A	Implementation of the Hartlepool Youth Investment Project	Patrick Wilson/Tom Argument	September 2014

OUTCOME 5: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL
LEAD OFFICER:

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Child Poverty Strategy
- Children's and Young People's Plan
- Public Health Transition Plan
- Clinical Commissioning Group Commissioning Plan

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Hartlepool and Stockton Clinical Commissioning Group

OBJECTIVE A: ADDRESS THE IMPLICATIONS OF WELFARE REFORM

REF.	ACTION	ASSIGNED TO	DUE DATE
	Implement and review Discretionary Council Tax Support Framework	Julie Pullman	December 2013
	Respond to Welfare Reform changes by engaging and supporting affected households	Julie Pullman	March 2014
	Develop partnership outreach process to ensure that families understand and plan for Welfare Reform	Danielle Swainston	March 2014
	Support workforce to identify risk factors re: child poverty/welfare reform and implement appropriate packages of support	Danielle Swainston	March 2014
	Implement a programme of Benefits and Free	Julie Pullman	March 2014

	School Meals take up initiatives		
	Develop referral channels for adults to access financial advice services and financial products	John Morton	March 2014

OBJECTIVE B: MITIGATE AGAINST THE IMPACT OF POVERTY AND UNEMPLOYMENT ACROSS THE TOWN

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Fuel Poverty	HBC	TBC	TBC
Proportion of children living in workless households	DWP	Annually	

REF.	ACTION	ASSIGNED TO	DUE DATE
	Develop training package for family workforce to identify poverty issues and support parents in poverty	Danielle Swainston	March 2014
	Increase the parental employment rate	Anthony Steinberg	March 2015
	Improve skill levels in parents and children	Danielle Swainston	March 2015

OUTCOME 6: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LEAD OFFICER: MAYOR STUART DRUMMOND, PORTFOLIO HOLDER FOR REGENERATION & NEIGHBOURHOODS , HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Housing Strategy
- Housing, Care & Support Strategy
- Fuel Poverty Strategy
- Public Health Transition Plan
- Crime & Disorder Strategy
- Local Transport Plan
- Community Cohesion Strategy
- Climate Change Strategy
- Neighbourhood Management and Empowerment Strategy
- Parks and open space

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- Housing Partnership
- Safer Hartlepool Partnership

OBJECTIVE A: DELIVERING NEW HOMES AND IMPROVE EXISTING HOMES, CONTRIBUTING TO SUSTAINABLE COMMUNITIES

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
New homes constructed to lifetime homes standard	Housing Monitoring System HBC	Quarterly	50
Sustainable homes constructed	Housing Monitoring System HBC	Quarterly	50
Number of properties improved through the grants or loans schemes	Authority Public Protection (APP) System HBC	Quarterly	None – the numbers of properties improved will depend on funding – the overall aim to reduce waiting list
Number of long term (over 6 months) empty homes brought back into use	Authority Public Protection (APP) System and Council Tax data HBC	Quarterly	10% of long term (over 6 months) empty homes brought back into use annually
Number of social rented houses fitted with renewables such as Photo Voltaic panels and/or cells, solar hot water and air source heat pumps	RP Management Systems All Registered Providers	Annually	50
Number of excess cold HHSRS Category 1 hazards rectified	Authority Public Protection (APP) System	Quarterly	None – the number of complaints received on an

	HBC		annual basis will vary

REF.	ACTION	ASSIGNED TO	DUE DATE
HS1A4 (proposed replacement action)	Monitor the schemes included in the 2011-15 NAHP programme and report any changes to the Housing Partnership.	Nigel Johnson	March 2015
1B1	Continue to achieve an improvement in the number of private sector homes constructed to lifetime home standards and relevant government energy efficiency levels.	Planning Services Manager Chris Pipe	March 2014
HS1C3 (proposed replacement action)	Monitor the progress of acquisition on the Carr/Hopps Street regeneration scheme	Amy Waller; Nigel Johnson	March 2015
New proposed action from 2D4	Work with landlords to prevent homes from becoming long-term empty through early intervention.	Amy Waller	March 2015
HS2E2	Support landlords to carry out energy efficiency works to deal with excess cold hazards through education and promotion of the benefits	Housing Services Manager Nigel Johnson	March 2015
HS2E4	Explore opportunities and options for encouraging property owners to retrofit homes with renewables such as Photo Voltaic panels and/or cells solar hot water and air source heat pumps	Principal Policy Officer Valerie Hastie	March 2015

OBJECTIVE B: CREATE CONFIDENT, COHESIVE & SAFE COMMUNTIES

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Reduce perceptions of anti-social behaviour	Viewpoint Hartlepool Borough Council	Biannual	Reduce in comparison to baseline year – 29%
Maintain perception level of drunk/rowdy behaviour as a problem	Viewpoint Hartlepool Borough Council	Biannual	Maintain in comparison to baseline year – 25%
Reduce anti-social behaviour (asb) incidents reported to the police	Police recorded (asb) incidents – Cleveland Police	Quarterly	Reduce in comparison to baseline year – 8,779
Increase the number of recorded hate incidents	Recorded Crimes and Incidents – Cleveland Police, Housing Hartlepool and Hartlepool Borough Council	Quarterly	Increase in comparison to the baseline year – 98
**Domestic Abuse	NI32		
**Violent Crime (including sexual offence)	TBC		
**Reoffending	HBC		
**Percentage of population affected by noise	TBC		
** Utilisation of green space for exercise / health	National Environment		

reasons	Survey		
**Social connectedness	TBC		
**Older Peoples perception of community safety	TBC		

REF.	ACTION	ASSIGNED TO	DUE DATE
	Implement the PREVENT action plan as guided by the Silver group.	Sally Forth	March 2014
	Develop new Anti-Social Behaviour Strategy and action plan in line with Government policy	Sally Forth	March 2014
	Monitor the implementation of the community cohesion framework action plan	Adele Wilson	March 2014
	In conjunction with partners improve reporting, recording, and responses/interventions to vulnerable victims and victims of hate crime.	Nicholas Stone	March 2014
	Introduce restorative practice across Safer Hartlepool partners to give victims a greater voice in the criminal justice system.	Sally Forth	March 2014

OBJECTIVE C: ENSURING APPROPRIATE GOVERNANCE IS IN PLACE THAT ENABLES THE MEANINGFUL PARTICIPATION AND EMPOWERMENT OF COMMUNITIES IN LOCAL GOVERNMANT DECISION MAKING PROCESSES

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
Percentage of residents feeling that they can influence decisions that affect their local area	HBC	Annual	Monitored

REF.	ACTION	ASSIGNED TO	DUE DATE
	Support the delivery of Face the Public Events by the Strategic Partners Group and Theme Groups	Catherine Grimwood	March 2014

OBJECTIVE D - PREPARE FOR THE IMPACTS OF CLIMATE CHANGE AND TAKE ACTION TO MITIGATE THE EFFECTS

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI185 – CO_2 reduction from local authority operations	NI185 outturn produced by Council	Financial Year	7% (currently under review, and will be smaller for 2013/14)
NI186 – Per capita CO_2 emissions from the local authority area	NI186 outturn produced by Department for Energy & Climate Change	Calendar Year	3.75%
NI188 – Planning to Adapt to Climate Change	NI188 outturn produced by Council	Financial Year	Level 4 by end 2013/14

**Air Pollution	TBC		
**Public Sector organisations with board approved sustainable development management plan	TBC		

REF.	ACTION	ASSIGNED TO	DUE DATE
	Implement actions of the Joint Strategic Needs Assessment (JSNA) Scrutiny review with regard to the environment.	Paul Hurwood	Mar 2014
	Consult and promote a community 'Collective Energy Switching' programme throughout the borough	Dave Hammond / Paul Hurwood	Mar 2014

OBJECTIVE E - ENSURE SAFER HEALTHIER TRAVEL

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
NI47- People killed or seriously injured in road traffic accidents	Cleveland Police & Hartlepool Borough Council	Annually	Yes
NI48- Children killed or seriously injured in road traffic accidents	Cleveland Police & Hartlepool Borough Council	Annually	Yes

REF.	ACTION	ASSIGNED TO	DUE DATE
	Safer Routes to School	Paul Watson/Peter Frost	Annual programme
	School 20mph zones	Peter Frost	Annual programme
	Road Safety education and training	Paul Watson	Annual programme

OUTCOME 7: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LEAD OFFICER: LOUISE WALLACE, DIRECTOR OF PUBLIC HEALTH, HBC

CONTRIBUTING STRATEGIES / PLANS / PROGRAMMES:

- Immunisation Strategy
- Alcohol Harm Reduction Strategy
- Stop Smoking Action Plan
- Tobacco Alliance Plan
- Cardiovascular Disease Programme Plan
- National Early Detection & Awareness of Cancer Plan
- Flu Plan (Seasonal)
- Clinical Commissioning Group Commissioning Plan
- Public Health Transition Plan
- Breastfeeding Strategy
- Health Schools
- Healthy Weight, Healthy Lives Strategy
- Vision for Adult Social Care in Hartlepool
- Mental Health Strategy
- Drug Treatment Plan
- Health & Safety Service plan
- Food Law Enforcement Plan
- Alcohol Licensing Policy
- Trading Standards Service Plan
- Food Sampling Policy
- North East Outbreak Control Policy

CONTRIBUTING ORGANISATIONS / GROUPS:

- Hartlepool Borough Council
- North Tees & Hartlepool NHS Foundation Trust
- Hartlepool & Stockton Clinical Commissioning Group
- Immunisation Strategy Group
- Coronary Heart Disease Local Implementation Team
- Diabetes Local Implementation Team
- British Heart Foundation Group
- 'Be Healthy' Groups
- Alcohol Strategy Group
- HPA / Public Health England
- FRESH
- BALANCE

OBJECTIVE A: REDUCE THE NUMBER OF PEOPLE LIVING WITH PREVENTABLE ILL HEALTH AND DYING PREMATURELY

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Healthy life expectancy	ONS		
** Sickness absence rate: Percentage of employees who had at least one day off sick in the previous week / Number of working days lost due to sickness absence.	TBC		
** Sickness absence rate: Rate of fit notes issued per quarter	TBC		

**Differences in life expectancy and health expectancy between communities	TBC		
**Diet	TBC		
**Excess weight in adults	TBC		
**Successful completion of drug treatment	National drug treatment monitoring system		
**People entering prison with a substance dependence issue who are not previously known to community treatment	TBC		
2.18 Alcohol related admissions to hospital	Hospital Episode Stats		
2.17 recorded diabetes	Quality management analysis system		
2.18 Alcohol related admissions to hospital	Hospital Episode stats		
**Access to non cancer screening programmes : infectious disease testing in pregnancy – HIV, syphilis, hepatitis B, and susceptibility to rubella	TBC		
**Access to non cancer screening programmes : Antenatal sickle cell and thalassaemia screening	TBC		
**Access to non cancer screening programmes : Newborn blood spot screening	TBC		
**Access to non cancer screening programmes : Newborn hearing screening	TBC		
**Access to non cancer screening programmes : Newborn physical examinations	TBC		
**Access to non cancer screening programmes :Diabetic retinopathy	TBC		
**Take up of the NHS Health Check programme – by those eligible	TBC		
**Self reported wellbeing	TBC		

**Chlamydia diagnoses	TBC		
**Population vaccination coverage	TBC		
**People presenting with HIV at a late stage of infection	TBC		
**Treatment completion for tuberculosis	TBC		
**Comprehensive inter-agency plans for dealing with public health incidents	TBC		
**Mortality rate from causes considered preventable	ONS		
**Under 75 mortality rate from all cardiovascular diseases	ONS		
**Under 75 mortality from cancer	ONS		
**Under 75 mortality from liver disease	ONS		
**Under 75 mortality from respiratory disease	ONS		
**Mortality from infectious and parasitic diseases	ONS		
**Emergency readmissions within 30 days of discharge from hospital	ONS		
**Preventable sight loss	Certificate of Visual impairments		
**Health related quality of life for older people	TBC		

REF.	ACTION	ASSIGNED TO	DUE DATE
	Commission a comprehensive healthy heart check programme for all eligible people across Hartlepool	Director of Public Health	March 2014
	Commission a comprehensive range of accessible and equitable sexual health services	Director of Public Health	March 2014
	Develop a comprehensive health protection plan for Hartlepool and provide assurance that the health of then population is comprehensively protected	Director of Public Health	March 2014
	Commission a comprehensive range of services to	Substance Misuse Joint	March 2014

	reduce the individual and community impact of alcohol related harm	Strategy Group / Director of Public Health	
	Commission services to ensure people maintain a healthy weight and a healthy life.	Healthy Weight Healthy Lives Strategy Group	March 2014
	Deliver a comprehensive programme to improve workplace health	Director of Public Health	March 2014
	Ensure effective integrated treatment of drug and alcohol services	Chris Hart	March 2014

OBJECTIVE B: REDUCE THE HEALTH INEQUALITY GAP BETWEEN COMMUNITIES ACROSS HARTLEPOOL

Performance Indicator	Data Source & Responsible Organisation	Collection Period	Annual Target
**Fuel Poverty	English Housing Survey		
**Proportion of physically active and inactive adults	TBC		
**Smoking prevalence adults	Integrated Health Survey		
**Cancer diagnosed at stages 1 & 2	TBC		
**Cancer screening coverage	TBC		
**Injuries due to falls in people aged 65 and over	TBC		
**Under 75 mortality rate from al cardiovascular diseases	ONS		
**Under 75 mortality from liver disease	ONS		
**Under 75 mortality from respiratory disease	ONS		
**under 75 mortality rate from cancer	ONS		
**Excess under 75 mortality rate in adults with serious mental illness	TBC		
**Suicide rate	ONS		

**Hip fractures in people aged 65 and over	Hospital Episode Stats		
**Excess winter deaths	ONS		
**Dementia and its impacts	TBC		

REF.	ACTION	ASSIGNED TO	DUE DATE
	Commission a comprehensive range of services to enable people to stop smoking	Director of Public Health	March 2014
	Develop a comprehensive systematic approach for addressing excessive winter deaths	Director of Public Health	September 2014
	Commission services to promote positive mental health and well being	Director of Public Health	March 2014
	Promote the early detection and awareness of signs and symptoms of cancer across Hartlepool	Director of Public Health	March 2014
	Develop a comprehensive programme of accident prevention	Director of Public Health	March 2014

Department	Division	Section	Owner/Officer
Child and Adult Services	*Public Health*	*Public Health*	*Louise Wallace*

Function/ Service

Hartlepool Joint Health and Wellbeing Strategy 2013-18

The NHS reform requires the Local Authority with partner agencies, including the Primary Care Trust (PCT) and Clinical Commissioning Group, to develop a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment (JSNA). The final draft of the strategy must be completed by April 2013. The strategy should focus on not only protecting the health of the population but improving it through a range of evidence based interventions.

The Joint Health and Wellbeing Strategy (JHWS) is a high-level summary outlining how Hartlepool Borough Council, Hartlepool Clinical Commissioning Group and other key organisations will address health and wellbeing needs of Hartlepool and help reduce health inequalities.

The Health and Social Care Bill (2011) establishes Health and Wellbeing Boards as statutory bodies responsible for encouraging integrated working and developing a Joint Strategic Needs Assessment and Health and Wellbeing Strategy for their area. The JHWS is underpinned by the Joint Strategic Needs Assessment (JSNA) and together they will provide a foundation for strategic evidence-based, outcomes-focused commissioning and planning for Hartlepool.

The JHWS supports the ten themes of *Better Health, Fairer Health* (2008) – The North East's vision and 25 year plan for improving health and wellbeing. The ten themes being:

- Economy, culture and environment
- Mental health, happiness and wellbeing
- Tobacco
- Obesity, diet and physical activity
- Alcohol
- Prevention, fair and early treatment
- Early life
- Mature and working life
- Later Life
- A good death

The strategy focuses on areas of work impacting directly on health and wellbeing, or acting as clear 'wider determinants' of health and wellbeing:

- Health care services (including health protection)
- Social care services
- Individual lifestyle factors
- Social and community networks
- Housing

	• Employment • Environment The strategy is underpinned by the Marmot Report 2010.
Information Available	*You should consider what information you hold in order to give proper consideration to the Equality Duty. You will need to draw upon local, regional and national research particularly if internal information is scarce. Include any consultation carried out* Whilst health in Hartlepool is generally improving, it is still worse than the national average. Levels of deprivation are higher and life expectancy is lower than the national average. Both the death rate from smoking; and the percentage of mothers smoking in pregnancy are worse than the England average. Alcohol-related hospital admissions are higher than the national average and childhood immunisation rates are significantly lower than the national average. Key outcomes and objectives for the strategy have been developed in consultation with the public, service users and partner organisations, through the Local Involvement Networks (LINks) membership on the Health and Wellbeing Board, democratically elected member representation on the Board and a consultation process. The Strategy consultation ran from June – October 2012. It consisted of: A face to face public event – attended by approximately 70 people representing a range of organisations from the community, voluntary and statutory sector and elected members. A resource-allocation exercise – set up in a range of venues including the shopping centre, the library, children's centres, GP surgeries and youth centres. The exercise asked members of the public to allocate £25 virtual pounds across Marmot policy areas these being: • Give every child best start in life; • Enable all children and Young People to maximise capabilities; • Enable all adults to maximise capabilities; • Create Fair Employment and good work for all; • Ensure a healthy standard of living for all; • Create and develop healthy and sustainable places; • Strengthen the role and impact of ill health prevention. A total of 465 participants took part in the exercise. 'Giving every child the best start in life' was the most popular priority across all the venues with 'ensuring a healthy standard of living for all' was second most popular. An online survey – asked respondents to prioritise a range of suggested interventions listed under each Marmot policy area.

	Respondents were asked to choose the 3 most important issues under each Marmot area. Data from the survey was aggregated together with the findings from the resource-allocation exercise and consultation with the LINk to become the basis of the draft strategy. The draft strategy was also shared with the Clinical Commissioning Group. Key outcomes and objectives have been developed with the following in mind: • Local authority 'mandated' services • Clinical Commissioning Group draft plans • Current JSNA commissioning intentions • Hartlepool Public Health Transition Plan.	
Relevance *Identify which strands are relevant to the area you are reviewing or changing*	**Age**	√
	Disability	√
	Gender Re-assignment	
	Race	√
	Religion	√
	Gender	√
	Sexual Orientation	
	Marriage & Civil Partnership	
	Pregnancy & Maternity	√
Information Gaps	*Are there any gaps in your information and, if so, what further information do you need? What involvement or consultation is needed? How will it be done? You must also ensure compliance of any third parties which carryout functions on you behalf.* As demonstrated, we have undertaken a considerable consultation exercise and we are able to analyse the data collected from the different locations where the consultation took place. However, we are aware that we are not able to analyse the data to ascertain demographic information and identify any particular characteristics that we might not have involved. It is possible that the data might be skewed as a result of the venue where the consultation took place. We have not consulted with any specific user groups such as people with a learning difficulty, those with mental health issues or people form the LGBT community. However, we are aware that the work undertaken for the JSNA has included consultation with these groups and as the strategy is underpinned by the JSNA, we can assume some input from those groups.	

What is the Impact	*Consider the impact of the policy/service/function in respect of the three aims of the Equality Duty, this must form an integral part of your decision making process and in such a way that influences the final decision.* The strategic key outcomes for the strategy have been identified as being: • Every child has the best start in life • Reduce the gap in life expectancy • Improving wellbeing for those with long-term conditions Work on these outcomes will begin through tackling health inequalities and building social capital. A work programme is being developed that will support these objectives and ultimately improve the outcomes of the population of Hartlepool. Whilst some of the key strategic outcomes identified target a specific equality group or community such as children, the cumulative impact of the outcomes is beneficial to the population of Hartlepool as a whole. We would anticipate that implementation of the strategy would help fulfil the aims of the Equality Act 2010 by improving the health and wellbeing, reducing health inequality and improving efficiencies for the whole population of Hartlepool.
Addressing the impact	*The outcome of the impact assessment may be one or more of the following four outcomes; You must clearly set out your justification for the outcome/s.* **1. No Impact- No Major Change -** *It is clear that there is no potential for discrimination or adverse impact on the above Protected Characteristics. All opportunities to promote Equality have been taken and no further analysis or action is required.*
	~~2. Adjust/Change Policy -~~ *~~You may have to make adjustments to address potential problems or missed opportunities that impact adversely on those with protected characteristics.~~*
	~~3. Adverse Impact but Continue -~~ *~~Your decision may be to continue without making changes, this may be the right outcome even if your assessment identifies the potential for adverse impact. (E.g. Cabinet decision to withdraw a service).~~*
	~~4. Stop/Remove Policy/Proposal –~~ *~~Your assessment reveals unlawful discrimination it must be stopped and removed or changed.~~*

Actions

It will be useful to record and monitor any actions resulting from your assessment to ensure that they have had the intended effect and that the outcomes have been achieved.

Action identified	Responsible Officer	By When	How will this be evaluated?
Consider	**Louise Wallace**	**March 2013**	**Broader involvement in the**

broader consultation of the strategy to include specific characteristics such as older people and people from the BME communities			**development of the strategy.**
Look at the consultation undertaken as part of the JSNA and ensure broad involvement/identify gaps.	**Louise Wallace**	**March 2013**	**Gaps identified for future consultation.**
Consider targeted consultation on such groups as people with a learning disability and people with mental health difficulties.	**Louise Wallace**	**March 2013**	**Broader involvement in the development of the strategy.**

Date sent to Equality Rep for publishing	00/00/00
Date Published	00/00/00
Date Assessment Carried out	00/00/00

Hartlepool Health Improvement Service

Immunisations 2012

Briefing Update

1. Introduction

The purpose of this briefing is to update Members of the Health Scrutiny Forum about the progress being made towards the uptake of immunisations. For the purpose of this paper the routine childhood immunisation programme and at risk programme ~ seasonal influenza will be presented.

A child born in Hartlepool can expect to receive at least seven injections in their first year of life. By the time they get to 18 years of age they would have received at least 16 separate injections (13 for boys) that protect each child against 10 vaccine preventable diseases (11 for girls).

2. Childhood Vaccines

The World Health Organisation (WHO) recommends that at least 95% of children receive three primary doses of diphtheria, tetanus, polio and pertussis in the first year of life and more that 95% receive one dose of measles, mumps and rubella vaccine by two years of age.

Currently all childhood immunisations, with the exception of the school leaver booster and Human Papillomavirus (HPV) are delivered through GP practice and supported by the health visiting teams. The schedule for the programme starts when a child is 2 months old, please see appendix 1 for a description of the current routine immunisation schedule.

2.1 Vaccine coverage targets

Table 1 ~ primary immunisation course by 12 months 2010/11

Vaccine	Hartlepool	North East	England	Target
D/TaP/IPV/Hib	92.4%	95.5%	94.2%	95%
MenC	92%	95.4%	93.4%	95%
PCV	91.5%	95.5%	93.6%	95%

Table 1.1 ~ primary immunisations course by 12 months 2005/6 – 2010/11

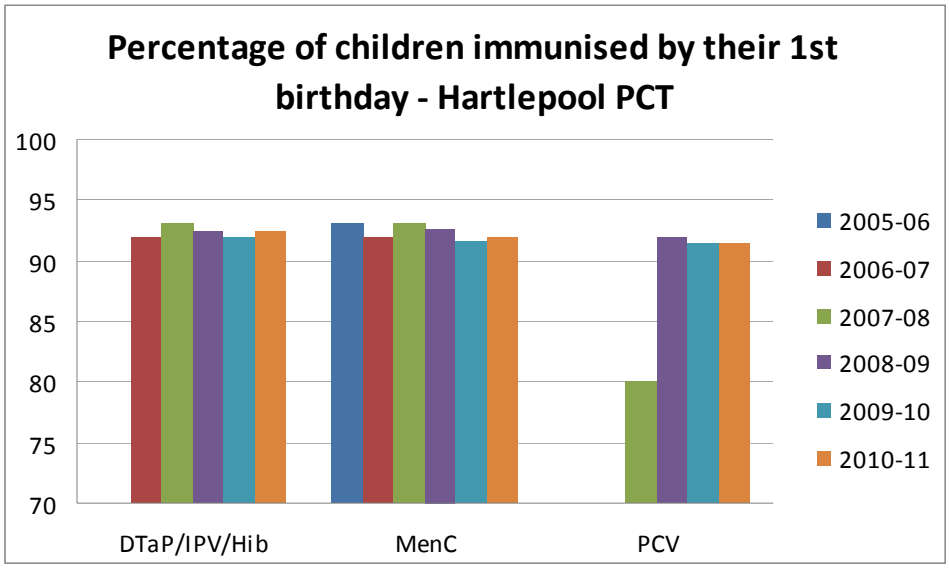


Table 2 ~ child immunisation course by 24 months 2010/11

Vaccine	Hartlepool	North East	England	Target
MMR (1)	85.4%	91.4%	89.1%	95%
Hib/MenC booster	87.5%	94.6%	91.6%	95%
PCV booster	85.1%	94.6%	89.9%	95%

Table 2.1 ~ % of Hartlepool children immunised against MMR compared to the North East and England averages

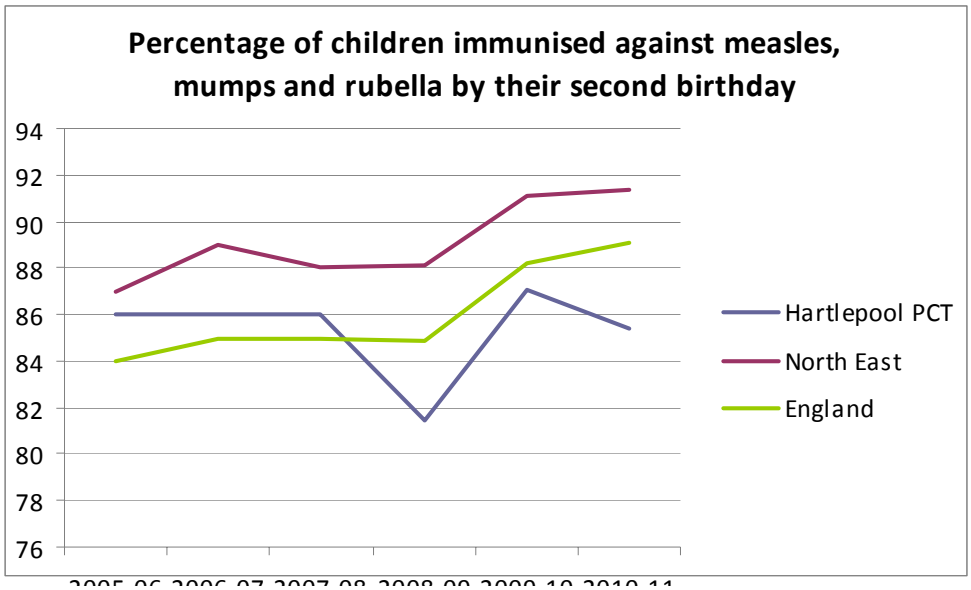
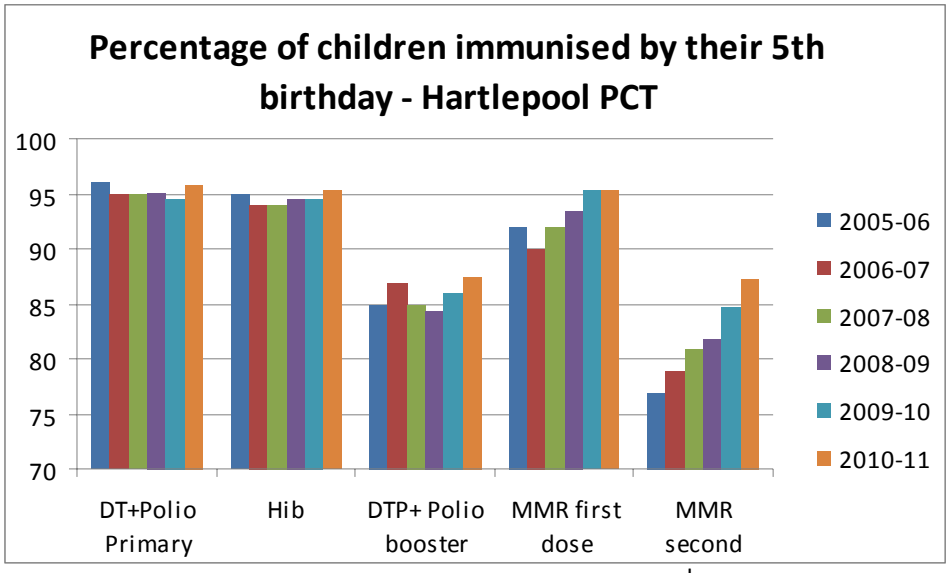


Table 3 ~ completed Primary immunisations and boosters by 5 years 2010/11

Vaccine	Hartlepool	North East	England	Target
MMR (2)	87.2%	88.7%	84.2%	95%
D/TaP/IPA	87.4%	90.5%	85.9%	95%

Table 3.1 ~ % of children immunised by their 5th birthday 2006/06 to 2010/2011



2.2 Human Papillomavirus

The aim of the Human Papillomavirus (HPV) vaccine is to reduce the incidence of cervical cancer in women. Young women have 3 doses of the HPV vaccines before they reach an age when the likelihood of HPV infection increases and they are put at risk of cervical cancer. In Hartlepool the HPV programme is delivered in Year 8 and is delivered through a school based service.

In England 84.2% of females aged 12 – 13 years who were eligible to receive HPV vaccine in the academic year completed the three dose course. In the North East 87.5% of girls in this cohort completed the three dose course. In Hartlepool 90.2% of girls eligible completed the three dose course which is significantly higher than the North East and England average.

3. At Risk Programme ~ Seasonal Flu

Influenza (flu) can potentially be a life threatening condition resulting in serious illness particularly for those in the at risk groups. The Department of Health currently recommends to reach, or exceed, the target of 75% for all individuals aged over 65 years and older as recommended by the World Health Organisation (WHO). Current national policy advises that seasonal flu vaccine should be offered to:

- All aged 65 and older
- Individuals aged 6 months or over in a clinical risk group

- Those living in long stay residential care facilities
- Those in receipt of a carer's allowance or those who are the main carer of an elderly or disabled person
- All pregnant women
- Frontline health and social care workers

At risk groups who should receive influenza vaccine include individuals with:

- Diabetes
- Chronic respiratory disease
- Chronic heart disease
- Chronic kidney disease
- Chronic liver disease
- Chronic neurological disease
- Individuals who are immunosuppressed

Table 4: Seasonal flu vaccine uptake: 2009/10 to 2011/12

Organisation	65 and over			Under 65 (at risk only)		
	2009/10	2010/11	2011/12**	2009/10	2010/11	2011/12**
Hartlepool*	72.3	71.8	73.0	57.1	52.9	52.0
North East	73.9	74.5	75.8	52.6	52.0	53.7
England	72.4	72.8	-	51.6	50.4	-

*denotes PCT with less than a 100% response rate (Hartlepool 93%)
** denotes provisional data

3.2 Pregnant Women

Seasonal flu vaccine is recommended for all pregnant women, irrespective of their stage of pregnancy. Flu immunisation of women:

- Reduces rates of influenza among pregnant women
- May reduce the likelihood of prematurity and smaller infant size and weight at birth associated with influenza during pregnancy
- Provides passive immunity against flu to infants in the first few months of life

Table 5: Season flu vaccine uptake in pregnant women: 2011/12

Organisation	Pregnant and NOT IN a clinical risk group**	Pregnant and IN a clinical at risk group**	All pregnant women (combined)**
Hartlepool*	25.2	43.1	26.4
North East	31.4	54.8	33.3
England	-	-	-

*dentes PCT with less than a 100% GP response rate (Hartlepool 93%)
** denotes provisional data

Appendix 1: Current routine child immunisation schedule

When to immunise	What is given	Protection
Two months old	Diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b (DTaP/IPV/Hib) ***1st Dose***	Protects against: diphtheria, tetanus, pertussis (whooping cough), polio and haemophilus influenza (type b)
	Pneumococcal (PVC) ***1st Dose***	Protects against pneumonia, middle ear infection, some forms of septicaemia, pneumococcal meningitis
Three months old	Diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b (DTaP/IPV/Hib) ***2nd Dose***	Protects against: diphtheria, tetanus, pertussis (whooping cough), polio and haemophilus influenza (type b)
	Meningitis C (MenC) ***1st Dose***	Protects against: meningococcal type C, a type of bacteria that can cause meningitis and septicaemia
Four months old	Diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b (DTaP/IPV/Hib) ***3rd Dose***	Protects against: diphtheria, tetanus, pertussis (whooping cough), polio and haemophilus influenza (type b)
	Pneumococcal (PVC) ***2nd Dose***	Protects against pneumonia, middle ear infection, some forms of septicaemia, pneumococcal meningitis
	Meningitis C (MenC) ***2nd Dose***	Protects against: meningococcal type C, a type of bacteria that can cause meningitis and septicaemia
Within a month of the first birthday	Haemophilus influenzae type b, Meningitis C (Hib/MenC) ***Booster Dose***	Protects against: haemophilus influenza (type b) and meningitis C
	Measles, mumps and rubella (MMR) ***1st Dose***	Protects against measles, mumps and rubella
	Pneumococcal (PVC) ***3rd Dose***	Protects against pneumonia, middle ear infection, some forms of septicaemia, pneumococcal meningitis
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio (DTaP/IPV) *Pre school booster dose*	Protects against: diphtheria, tetanus, pertussis (whooping cough) and polio
	Measles, mumps and rubella (MMR) ***2nd Dose***	Protects against measles, mumps and rubella
Girls aged 12 – 13 years	Human Papillomavirus Vaccine (HPV) ***3 injections given at 0, 1.2 months and 6 month intervals***	Protects against the HPV virus which has been shown to cause cervical cancer
Thirteen to 18 years old	Tetanus, diphtheria and polio (Td/IPV) ***Teenager Booster Dose***	Boost protection against tetanus, diphtheria and polio

IMMUNISATION STRATEGY 2011-2012, NHS TEES (draft copy)

Peter Kelly's forward

After clean water immunisation is the most effective public health intervention in the world, saving lives and promoting good health Immunisation plays a critical part in preventing ill health and helping people lead healthier lives etc

1.0 Introduction

Immunisation is generally regarded as one of the most effective and cost- effective public health interventions in modern health care. It is also one of the few direct health interventions that can be quantified and measured. The importance of immunisation has been re-determined recently with the H1N1 pandemic which highlighted the need for worldwide preventative measures to be deployed promptly and safely on a considerable scale. The impact of this programme raises two issues, namely the importance of a sustainable and robust immunisation strategy to enable completion of the programme without detriment to other routine vaccination strategies and the collaboration of partner organisations to enable efficient implementation. Although the NHS is currently facing challenging times and the greatest transition that it has ever experienced, it is essential that we do not loose focus on the delivery of our public health agenda. The public health outcomes framework for England 2013-2016 (DH, 2012) gives reference to population vaccination coverage as a critical indicator to be taken to protect the public's health. Public health England will have a core role in the delivery of these improvements supported by NHS's and local authorities locally. 2012/2013 will be a crucial year in which further developments of the public health outcomes framework will emerge for this purpose although our key actions in this document will remain consistent, this strategy will remain a live and evolving document.

2.0 Background

2.1 Global Background

Around the world immunisation policy and strategy is largely based on the World Health Organisations (WHO) global policies. WHO is responsible for directing and co-ordinating public health policy across the globe and with regard to immunisation, for setting coverage rates and disease elimination targets such as for polio and measles

Global Alliance for Vaccines and Immunisation (GAVI), and the Expanded Programme on Immunisation (EPI), are two such programmes committed to ensuring all children throughout the world are vaccinated against vaccine preventable diseases (VPD). The success of these programmes can be measured in developing countries by the significant drop in mortality rates form VPD from one in four children (30 years ago) to a current level of one in 10 children (to reflect adults).

2.2 National Background

The DH and the JCVI receive advice from a variety of experts on subjects such as epidemiology, mathematical modelling and future predictions of infectious diseases, safety issues, quality control and public opinion. All these factors help to define, inform and develop immunisation policy in the UK . The effectiveness of the policy can be

measured in two ways. Firstly by the numbers of individuals vaccinated and secondly by the reduction in transmission of infectious disease or herd immunity. In September 2009 the National Institute for Health and Clinical Excellence (NICE) published public health guidance 21 'Reducing the difference in the uptake of immunisations', which focused on increasing immunisation uptake among children and young people aged under 19 years in groups and settings where immunisation coverage is low.

The guidance gives 6 clear recommendations to implement under the following headings:
1. Immunisation programmes
2. Information systems
3. Training
4. Contribution of nurseries, schools, FE colleges
5. Targeting groups at risk of not being fully immunised
6. Hepatitis B immunisation for infants

3.0 Local Position

2.3.1 Background

The challenges to achieve national uptake targets around children's immunisations, influenza and pneumococcal for older people, are well recognised in Teesside. Immunisations are also required throughout life to protect from travel and occupational related infections and it is essential that the population of Teesside have access to these, to protect themselves and their families. It is therefore a key responsibility of Tees Primary Care Trust to ensure vaccination programmes are commissioned and delivered in a well-organised and structured manner, in order to maximise the availability and uptake of vaccinations to achieve national targets, developing herd immunity to prevent outbreaks of infection.

The population of Teesside is approximately 550,000. There are four individual PCT`s who historically worked independently. Currently, there is one Tees wide Public Health Directorate served by two community provider services, one north of the river and one south.

The current position is that some of the childhood immunisation uptake rates across Teesside are falling below DH and local vital signs targets, the latter requiring an uptake rate of approximately 95% coverage in childhood immunisations to achieve herd immunity. This increases the risk of child morbidity from a variety of infectious diseases which are preventable through vaccination. Even in areas of good uptake there may be pockets of individuals who are unimmunised or partly immunised and therefore at risk from infectious disease as evidenced by the recent measles outbreak in Hartlepool 2009, shortly followed by the need to respond to the H1N1 Pandemic Vaccination Programme. Local uptake data can be seen in Appendix1. This impacted on our ability to be proactive towards increasing the vaccination uptake. Although various local and national initiatives have been implemented to improve uptake, this remains sporadic and uncoordinated. Additionally, methods of data collection vary across the patch and some discrepancies in data accuracy have been identified.

In May 2010 we were visited by the National Support Team (NST) to provide robust support to help meet national targets and improve our commissioning and delivery systems. The diagnostic visits from the NST to Tees PCT and local partners highlighted the challenges and opportunities of our current delivery system. The recommendations of the NST visit are highlighted briefly in the following 5 categories.

Five Key areas

1. Vision – the need for a systematic approach to immunisation and the development of a multi-disciplinary immunisation strategy and an immunisation action plan.
2. Data – Standardisation of data collection
3. Training – Review workforce requirements to ensure that there is a sustainable and skilled workforce
4. Industrialisation – Identify, evaluate and industrialise good practice across Teesside
5. Communication – Build on existing communication networks

2.3.2 Routine childhood immunisations
Currently all childhood immunisations, with the exception of the school leaver booster and HPV are delivered through GP practice (table 1) and supported by health visiting teams.
Responsibility for childhood immunisation however should not rest solely with the GP or practice nurse. The National Institute for Clinical Excellence (NICE) has produced guidance on "Reducing Differences in the Uptake Rates of Immunisation", which suggests:

- Improving access to immunisation services
- Adopting a multifaceted coordinated programme as part of local child health strategy
- Ensuring vaccination status is monitored as part of a wider assessment of child health
- Engaging and involving the wider population including, children's services, education, and other health professionals.

We recognise that a more flexible approach to vaccination is needed in order to provide a more equitable service across Teesside

Table 1

Age	Diseases Protected Against	Vaccine given	Location given
Two months old	Diphtheria, tetanus, pertussis (whoo ping cough), polio and Haemophilus influenzae type b (Hib) Pneumococcal infection	DTaP/IPV/Hib and Pneumococcal conjugate vaccine (PCV)	GP Practice
Three months old	Diphtheria, tetanus, pertussis (whoo ping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C)	DTaP/IPV/Hib and Men C	GP Practice
Four months old	Diphtheria, tetanus, pertussis (whoo ping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C) Pneumococcal infection	DTaP/IPV/Hib and Men C and PCV	GP Practice
12- 13 months	Haemophilus influenza type b (Hib) and meningitis C Measles, mumps and rubella (Germa n measles) Pneumococcal infection	Hib/MenC MMR and PCV	GP Practice
Three years and four months or soon after	Diphtheria, tetanus, pertussis and pol io Measles, mumps and rubella	DTaP/IPV or dTaP/IPV and MMR	GP Practice
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus types 16 and 18	HPV	School

13 to 18 years old	Tetanus, diphtheria and polio	Td/IPV	School
High risk groups all ages/ over 65 year olds	Influenza, Pneumonia	Influenza Pnuemococcal PPV	GP Practice/ Home visit
All ages	Hepatitis A and B, Rabies, Typhoid, Japanese encephalitis, Yellow fever etc	Travel vaccines	GP Practice/ private clinic

2.3.3 Adult immunisation schedule:
Influenza vaccination
The purpose of the seasonal flu immunisation programme is to offer protection to those who are most at risk of serious illness or death should they develop flu. National uptake targets are in place for influenza vaccine uptake in the over 65year olds and the at risk groups.

Uptake rates are as follows:

- 75% uptake for people aged 65 years and over as recommended by the WHO
- 75% uptake for people under age 65 with clinical conditions which put them more at risk from the effects of flu, and pregnant women, as recommended by the EU

A trajectory target for increases in uptake in clinical risk groups and pregnant women has been outlined as 60% in 2011/12, and 70% in 2012/13, so that an uptake of 75% can be reached or exceeded in 2013/14. As can be seen from the clinical risk uptake data below is somewhat of a challenge.

Transmission of flu health care settings can be significantly reduced by immunisation of health care workers. Uptake of flu vaccine in health care workers in Teesside can be seen below.

Routine vaccination of poultry workers is no longer included in the programme.

Table 2 . Seasonal Flu Vaccine Survey (GP) - February 2011 (1 Sep 10 to 28 Feb 11) % uptake rates

PCT	Over 65's	At risk	Pregnant women
Hartlepool	71.80%	52.90%	42.90%
Stockton	72.40%	48.10%	45.60%
Middlesbrough	75.10%	49.80%	35.10%
Redcar & Cleveland	78.10%	54.10%	45.40%

Pnuemococcal vaccination
Polysaccharide pneumococcal vaccine (PPV) is currently offered to all people over the age of 65 years. There is no currently no target for this vaccine and as highlighted in the next section the efficacy of this vaccine is questionable. However, pneumococcal disease is a major cause of morbidity and mortality in the elderly and individual vaccination should still be encouraged.

2.3.4 Changes to the immunisation schedules
Horizon scanning is important in order to prepare for changes in the current immunisation schedules (childhood and adult). Currently the Joint Committee for immunisation and Vaccination (JCVI) are examining evidence and have recommended:

- Changing the delivery of meningitis C vaccine to babies from 2 doses to 1 dose (with 12 month booster) and including an adolescent men C vaccination. Booster doses of other vaccines in adolescence are also being considered.
- Including other age groups 0-6 months and 5years to 18 years into the influenza programme. The impact of these changes on both Primary care and school nursing services could be immense and forward planning is necessary to ensure service delivery. Additionally a planned programme of public information and awareness raising is required as part of our strategy.

Epidemiological evidence has also shown that polysaccharide pneumococcal vaccine (PPV) does not significantly reduce invasive pneumococcal disease in the elderly and although this programme is still in place further considerations of this programme may possibly be made in the future.

Introduction of a herpes zosta vaccine for over 75 year olds is also being considered

2.3.5. Non routine immunisations
Hepatitis B for neonates
Without vaccination up to 90% of babies born to hepatitis B infected mothers will become chronic hepatitis B carriers, which in turn increases their risk of both cirrhosis of the liver and hepatocellular carcinoma in later life. About 25% of those infected in childhood will die from these causes. If these babies are vaccinated, in over 90% of cases, perinatal transmission can be avoided. Successful disease prevention can only be provided if the vaccinations are given according to the schedule.

In the two localities of Teesside (South Tees and North Tees) there are different service models currently employed to follow up babies once discharged from maternity services. Within this strategy we aim to ensure that there is a robust pathway in place to ensure vaccination and follow up of all babies born in Teesside.

Tuberculosis
Over the last 50 years, the demographic pattern of tuberculosis has changed from a disease which affected a wide range of the population to one which now predominately affects certain sub groups of the population with 2/3rds of the cases being born abroad. Due to the declining rates in the indigenous population, in 2005 the schools programme for BCG population was discontinued and replaced with a targeted vaccination programme for at risk groups. Locally the rate of TB diagnosis varies across Teesside.
Rates of TB diagnosis between 2007-2010 (source HPA):
Middlesbrough 17.8 per 100,000
Stockton 4.7 per 100,000
Hartlepool 6.6 per 100,000
Redcar and Cleveland 3.6 per 100,000
The national average is 15.3 per 100,000.

2.3.5 Child health information Systems
The implementation of child health information and reporting systems across Tees is currently very different in the South of Tees and North of Tees PCT areas.

In the two South of Tees PCT areas a single Child Health Information System (CHIS) records a comprehensive range of data relating to all children for whom the two South of Tees PCTs have responsibility. This single CHIS is managed by the Middlesbrough,

Redcar and Cleveland Community Services Child Health Records Department (MRCCS CHRD). Amongst other things the South of Tees CHIS provides lists of children in need of immunisation to all GP practices across the two South of Tees PCT areas. South of Tees GP practices return details of the childhood immunisations they have completed to the MRCCS CHRD so that the South of Tees CHIS can be kept up-to-date. In addition the MRCCS CHRD currently compiles the quarterly COVER reports for the two South of Tees PCT areas.

In the two North of Tees PCT areas, two different CHISs are in operation, one for each North of Tees PCT area. The range of data held within these CHISs is currently not as comprehensive as that held by the South of Tees CHIS. Neither of the North of Tees CHISs currently sends lists of children needing immunisation to the GP practices. The compilation and reporting of quarterly COVER data is carried out by the Tees PCTs Primary Care Informatics team (Tees PCI) which forms part of the Tees Directorate of Strategic Intelligence. Put simply, there are actually three different kinds of system in operation within the North of Tees PCT areas.
What has become apparent during the course of an evaluation exercise is that none of the child health information and reporting systems currently in operation across Tees is without fault or fully serves the needs of those that it endeavours to serve.

4.0 The Vision, aims and objectives

Our vision is that people of Teesside live longer, "healthier lives". Through this strategy we aim to fully protect people of Teesside against vaccine preventable diseases. We will strive to provide flexible vaccine programmes that will reflect the evolving needs of the population of Teesside.

It will also ensure that services deliver equitable immunisation programmes by being flexible to meet the needs of local communities. Utilisation of evidence from uptake data, horizon scanning to identify trends in population demographics and identifying new vaccine developments is important in informing developments to enable workforce and service delivery planning.

4.1 The aims of this strategy are:

- Reduce the risk of vaccine preventable disease by maximizing the uptake of vaccinations
- To achieve herd immunity in the Teesside population
- To ensure that immunisation services are equitable and accessible to all
- To provide high quality, standardised immunisation services through effective commissioning

4.2 The objectives of this strategy are:

Based on the 2009 NICE guidelines and aim to work in partnership with all key stakeholders across Tees to using a bottom up approach to develop an inclusive strategy which reflects that immunisation is every bodies business.

- **Immunisation programmes**. To provide a multifaceted, coordinated approach to immunisation programmes, improving access to services and providing tailored information and support.

- **Information systems**. Ensure NHS Tees child information systems are up to date reconciled and consistent.
- **Training**. Ensure that all staff who give and/or advice on immunisations are adequately trained in line with national minimum standards and competent to deliver this service.
- **Contribution of nurseries, schools, FE colleges.** Work in partnership with other organizations to promote and deliver immunisation programmes**.**
- **Targeting groups at risk of not being fully immunised**. Ensure immunisation services are accessible to all to address health inequalities and high risk groups are targeted appropriately.
- **Hepatitis B and BCG immunisation for neonates.** Develop a targeted and coordinated programme for neonates across acute and community settings.
- **Seasonal Influenza and Pneumococcal.** Increase uptake rates to reflect the DH trajectory over the next 3 years.
- **Other immunisation programmes:** Ensure HPV and BCG programmes are running effectively
- **Communication.** Develop an internal and external communication plan, paying particular attention to community engagement and a social marketing initiatives
- **Horizon scanning** to identify risks and trends in population demographics, and identify new vaccine developments to enable workforce and service delivery planning.

5.0 Progress and challenges

5.1 What progress have we made?

- ❖ We have an established immunisation strategy group
- ❖ We have established a governance structure for immunisation committees and sub groups
- ❖ We have previously developed some effective partnership working with local authorities during a recent measles outbreak and pandemic flu response.
- ❖ We have begun to develop links with the local Be Healthy groups, enabling us to share data and explore ways to improve immunisation uptake.
- ❖ We have established a hepatitis B stakeholder group and action plan for Teesside

5.2 What are the challenges?

- Maintaining focus throughout the current transitional phase and changes in the organisational and contractual delivery of health care services.
- Securing funding to support new initiatives
- Confusion regarding responsibility and accountability in delivering vaccine programmes
- PCT vital signs targets are higher than those of the services providers e.g. GPs
- Targets vary across the four PCT 's.
- Immunisation services do not offer patient choice or flexibility Clinic times and capacity not able to meet the demand for vaccination services not accessible due to demands of working hours.
- Securing funding for new initiatives

6.0 Performance management

In order to ensure the effectiveness of the strategy, continual monitoring of the uptake rates and performance of service providers is required.
This strategy will focus on commissioning high quality services to enable us to maximise uptake by achieving our objectives, focusing on raising awareness of the importance of immunisation across the community and ensuring that Teesside has a trained and skilled workforce to deliver immunisation programmes with the knowledge to inform families.

NHS Tees is committed to ensuring the population it serves is protected from vaccine preventable diseases and the following section of this strategy describes the outcomes and actions required to meet the objectives of this strategy, to ensure that vaccine preventable diseases are prevented by maximising uptake. These actions will be incorporated in commissioned contracts

- Continual monitoring of immunisation uptake at practice level and population level will ensure that areas of poor uptake are identified at an early stage and enable staff responsible for delivery to be alerted and actions to be put in place to improve uptake in a more pro-active response.
- Continual monitoring of performance against contracts as described within the Strategy will indicate progress and provide an early warning of a drop in uptake of immunisations.
- We can be assured that this strategy has been successful when we are reaching national targets equitably across Teesside. This will ensure that we do not have vulnerable groups of unvaccinated people in Teesside. The Immunisation Strategy Group will be responsible for monitoring the strategy and immunisation uptake and developing action plans to ensure that uptake continuously improves and is maintained across Teesside.

7.0 Governance

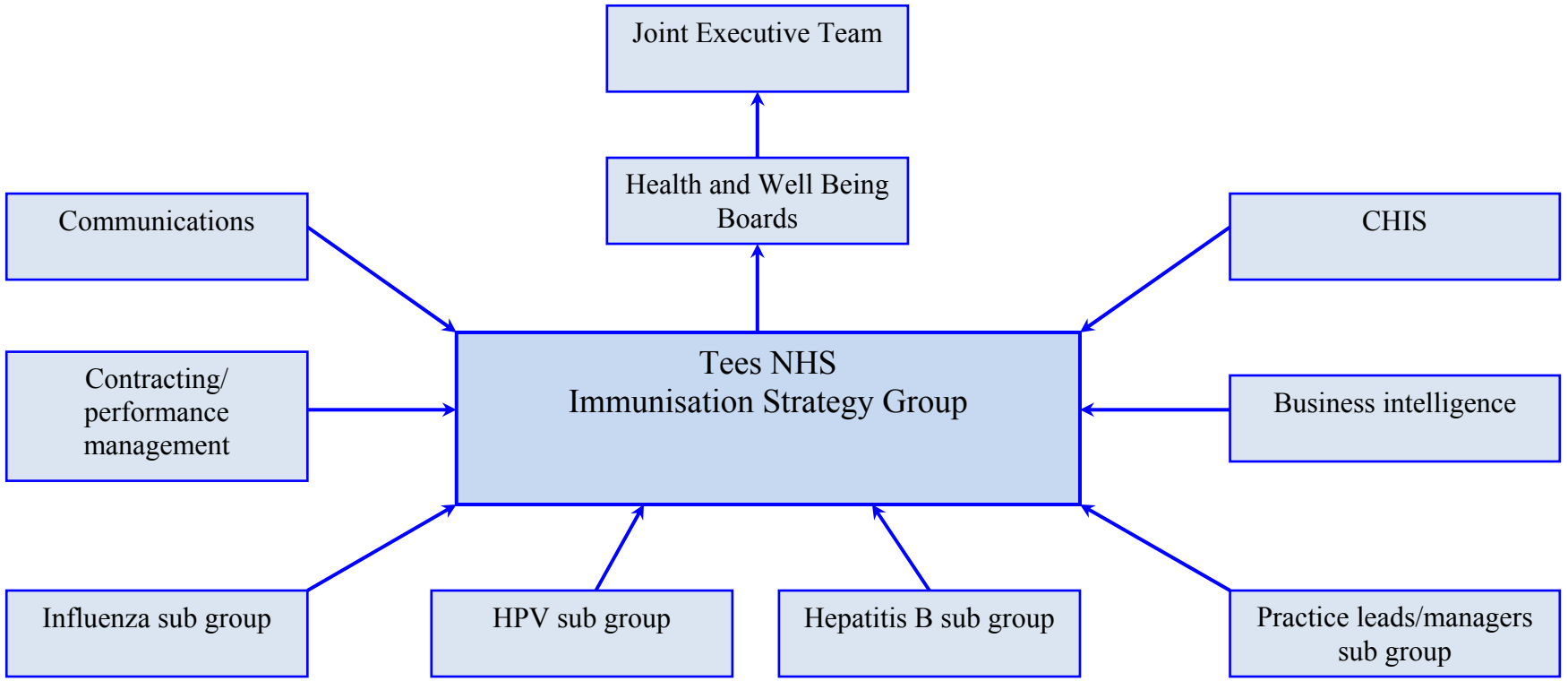
A number of groups will be responsible for the implementation and performance monitoring of the strategy. The public health contracts manager in collaboration with relevant contracting authorities provides overall co-ordination and support of the commissioning process.

The Immunisation Strategy will be implemented through the Immunisation Strategy Group.

Significant events involving vaccination will be reported according to PCT policy to ensure that lessons are learned from aspects of good and poor practice.

The NHS Tees Immunisation Strategy Group is responsible for:
_ Monitoring the strategy.
_ Developing and implementing the action plan.
_ Monitoring immunisation uptake.
_ Providing quarterly updates to health & wellbeing boards

Tees NHS Immunisation Strategy Governance Structure



8.0 Cost of implementing the strategy
It is anticipated that the majority of objectives in this strategy can be delivered through contracted services that are already in place with appropriate funding and therefore is cost neutral.

Changes in the National Immunisation Programme and additional campaigns attract new monies from the DH, which will be used to commission the delivery of the additional services and provide training where necessary.

Over the life of the strategy resources may need to be re-distributed depending on service development and cost implications against any current DES or LES will occur as uptake across all immunisations needs to increase to meet national targets.
Additional resources may be required for:

- Working more closely with schools and colleges
- Providing training where appropriate
- Reconciling child health information systems and GP practice records to ensure consistency.
- Ensuring accurate transfer of immunisation information between providers and between services
- and systems.
- Undertaking audit and quality assurance of immunisation records.
- Providing Outreach programmes for children from traveler, or new immigrant families.
- Providing home visits to parents who do not bring their children to attend immunisation appointments.
- Developing media campaigns
- Developing social marketing initiatives
- Developing immunisation awareness campaigns.

NHS Tees Action plans

9.0 Action plans :Are rated:
Priority 1 – to be completed in 12 months
Priority 2 – to be commenced within 12 months
Priority 3 - ongoing

Objective 1: Immunisation programmes

	Objective	Action	Priority	Progress	Who should take action
1.1	Develop a robust strategy group to monitor and deliver on the proposed action plans	Widen membership of strategy group to include Commissioners, managers and coordinators (PCTs), children's services, Sure Start children's centres and services for vulnerable groups, Health professionals responsible for children and young people's immunisation services e.g. paediatricians, health visiting and school nursing teams, GPs	P1	Group Established Dec11	Toks NC JL RF
1.2	Ensure there is an identified healthcare professional in the PCT and every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme	Contact Practice leads to establish a Practice leads sub group. Attend practice manager/nurse forums Work with the Practices to ensure leaders are identified and trained to take responsibility for immunisations and are aware of national and local guidelines. Work with Practice leads and practice managers and Health Visitors to address immunisation issues in Practice Work with Practices on the Vaccine Efficiency Savings Programme Audit (VESPA) Work with school nurses/health visitors to establish a seamless service in the community	P 1 P1 P1 P1	Employed extra PH nurse to work with Practices. Practices contacted regarding VNN and VESPA.	Public Health/ Primary Care Public health, Practice leads, Practice managers, medicines management

	Objective	Action	Priority	Progress	Who should take action
1.4	Improve access to immunisation services.	Work with practices on encouraging flexibility of immunisations appointments for parents/carers i.e extending clinic times, ensuring children and young people are seen promptly and by making sure clinics are child- and family-friendly. Work with primary care contracting on current requirements within GP contracts and how to use targets for payments. Work with local authority to establish and develop new services to capture "difficult to reach" patients "Pilot" community engagement model to improve immunisation uptake.	P1 P1	As above Regional DES in place Difficulties in data sharing has placed this programme temporarily on hold. Currently exploring possibility of making changes to Red Book to enable data sharing.	Public health, Practice leads, Practice managers, Public health/ Community services,/ NEPCSA/Contracting/CCG PH/Service providers/contracting local authority
1.5	Ensure Equitable immunisation programmes are delivered through flexible services to meet the needs of local communities.	Establish the requirements of both DES and LES contracts and formalise the process of renewal Contracts and Service level agreements will be reviewed to reflect changes in local and national targets. Performance will be managed and uptake data fed back to providers at quarterly meeting	P 1 P 1	Working with Contracting department and PCSA	PH/Contacting Contracting/PH

	Services will be planned taking into consideration the reasons for poor vaccine uptake,	Ensure Immunisation targets to are consistent across all four PCT's	P 2		PH/ PH
1.7	Ensure there are enough immunisation appointments available so that all young people and children can receive immunisations in a timely manner	Investigate with CHIS if this is a problem in Teesside	P2		PHF/PH/CHIS
1.8	Ensure young people and parents know how to access immunisation services and information.	Review content of GP contracts and service specifications include: _ Providing patients with tailored information, advice and support on the vaccinations and immunisation including the benefits and risks. _ Ensuring patients have the opportunity to discuss any concerns they might have about immunisations.	P2		PH/CCG/Practices/Comms

Objective 2: Information systems

	Objective	Action	Priority	Progress	Who should take action
2.1	Ensure PCTs and GP practices have a structured, systematic method for recording, maintaining and transferring accurate information on the vaccination status of all children and young people.	Set up sub group (CHIS working group)to look at the problems associated with information recording and dissemination	P1	Group formed April 2011	PH/CHIS/ PCI
		Meet with Practice Managers to discuss any concerns with CHIS	P1	Agreement from North Tees Practice Managers Specification developed for North Tees Foundation	PH/CHIS/ PCI
		Establish one centralised repository of data across North Tees.	P1	Agreement from LMC Dec11	PH/CHIS/ PCI
		Meet with Stockton and Hartlepool CCGs to secure agreement to proposal to merge CHIS across Teesside.	P1	Awaiting final signatures to contract	PH/CHIS/ PCI
	Monitor vaccination status as part of a wider assessment of children	Ensure data collection systems are in place to allow accurate reporting to GP and CHD.	P1		PH/CHIS/ PCI

	and young people's health	:			
2.2	Record any factors which may make it less likely that a child or young person will be up-to-date with vaccinations in their patient records and the personal child health record.	Investigate current practices and work with service providers to establish data sets.	P2		PH/Practices
2.3	Ensure up-to-date information on vaccination coverage is available and disseminated to all those responsible for the immunisation of children and young people.	Work with service providers to establish communication links through CHIS working group Gather information for practices and Public health on prospective numbers of children requiring information per quarter	P2		PCI PCI/CHIS

Objective 3: Training

	Objective	Action	Priority	RAG rating/progress	Who should take action
3.1	Ensure all staff involved in immunisation services are appropriately trained and updated regularly	Ensure service specification includes mandatory training requirement. Plan for provision of professional training from April 2012 Develop tier 2 and 3 training to deliver to all agencies in contact with families and young people	P2 P2 P2	Training commissioned for RN's HCW's, Midwives, Surestart workers	PH PH PH
3.2	Ensure training complies with national minimum standards	Investigate sources of appropriate training and obtain tenders	P1	Completed	PH

Objective 4: Contribution of nurseries, school, colleges of further education

	Objective	Action	Priority	Progress	Who should take action
4.1	Work with nurseries and schools to support immunization programmes.	Monitor practice of schools monitoring of vaccination status on school admission Engage with school nurses regarding immunisation uptake rates Formalise processes for feedback on coverage to CCGS/Scrutiny Panel/Children's Services	P1 P1 P1 P1	Awareness training for Surestart workers	PH School nurses
4.2	Work with community nurses to ensure systematic and consistent messages are delivered to parents	_ Establish links with local children centre leads. _ Ensure early years establishments have up to date information on immunisations. _ offer training to staff to advise young people and their parents about the vaccinations recommended at secondary school age and provide information in an appropriate format. Children's Services will be commissioned to	P1 P1 P1 P1		PH school nurses

		ensure immunisations are promoted at every possible opportunity including school education programmes Ensure that promotion of childhood immunisation is included in childhood specification	P1		

Objective 5 :Targeting groups at risk of not being fully immunised

	Objective	Action	Priority	Progress	Who should take action
5.1	Improve access to immunisation services for those with transport, language or communication difficulties, and those with physical or learning disabilities.	Audit in Practice what information is provided in different formats, for example, for those whose first language is not English Collate local data and analyse validity in order to assess as to whether specific population sub groups have low or high immunisation uptake rates. Utilise findings to commissioning services to increase access to areas or individuals with low immunisation uptake. Commissioned services will establish the reasons why children have failed to attend two or more appointments by contacting the parents or guardians and feed this information back to the Child Health department and will take action as far as possible to ensure that children who have failed to attend to appointments are immunised.	P2 P1 P1 P1	Working with practices to establish any problems	

		Work with local authority to establish and develop new services to capture "difficult to reach" patients "Pilot" community engagement model to improve immunization uptake.		Difficulties in data sharing has placed this programme temporarily on hold. Currently exploring possibility of making changes to Red Book to enable data sharing.	
5.2	Ensure Prison health services should check the immunisation history of all offenders	Establish links with prison nurses to determine current service and uptake for immunisation in this group Work with Offender Health on audit of local resources within prisons for immunisation	P2		
5.5	Ensure the immunisation status of looked after children is checked during their initial health assessment, annual review health assessment other statutory reviews.	Establish links with LAC nurses to determine current service and uptake for immunisation in this group	P1		

Objective 6:Hepatitis B immunisation for infants

	Objective	Action	Priority	Progress	Who should take action
6.1	Implement DH recommendations on hepatitis follow up for babies born to hepatitis B positive mothers (see sub group action plan)	Identifiy person responsible for coordinating the local Hepatitis B vaccination programme for babies. Establish a working group of stakeholders to implement the regional NESHA hepatitis B framework for the screening and vaccination of infants. Group to feed back to Immunisation strategy group 3 monthly. Develop an local action plan to implement necessary processes to achieve a robust and continuous service across Teesside Develop community follow up for neonatal hepatitis B Monitor programme and quality assurance in terms of patient safety and service delivery	P1 P1 P1 P1	In place Established Dec 11 Developed Dec 2011 Action plan in place LES developed for GP follow up to be discussed at the LMC	PH, maternity services, Acute services, community services, CCG's
6.2					

Objective 7: Seasonal influenza and pneumococcal uptake rates

	Objective	Action	Priority	Progress	Who should take action
7.1	Increase the awareness of the importance of increasing flu vaccine uptake amongst service providers	Provide feed back to Practices on uptake rates. Continue to identify practices with low uptake and work with practices to highlight areas of improvement Contact practice with good uptake to assess good practice Continue to ensure all service providers are trained and up to date with the relevant information on influenza Work with midwives to increase awareness of the importance of flu vaccine for pregnant women	P1 P1 P1 P1 P1	Steering group established Practices with lowest uptake in the at risk groups established and Commenced working with Work with individual practices Training for midwives- discussions in progress Establishing extent of GP's providing vaccination to care homes Establishing the extent of vaccination among health a social care workers	PCI & PH
7.2	Increase the awareness of the importance of increasing flu vaccine uptake amongst the public and at risk groups	Identify groups with low vaccine uptake and work with Communications department to produce information for the public highlighting the importance of flu vaccine for these groups	P1		Comms/PH
7.3	Increase uptake of flu	Increase awareness of the benefits of flu vaccine			

	vaccine amongst health care workers	both for the HCW and their patients	P1		Comms/PH
7.4	Ensure opportunistic pneumococcal vaccination is undertaken by service providers	Explore with practices what methods could be employed to improve pneumococcal uptake	P2		PH/commissioned providers

Objective 8: Other immunisation programmes: Ensure HPV and BCG programmes are running effectively

	Objective	**Action**	**Priority**	**RAG rating/progress**	**Who should take action**
8.1	HPV-Ensure service provider contracts are up to date and fit for purpose	Re establish HPV sub group to initiate communication on 2011/12 contract	Priority 1	Commenced Jan 2012	PH
8.2	HPV-Ensure systems are in place for up load of current data to open Exeter	To be included in the 2011/12 contract	Priority 1	In progess	
8.3	HPV- Ensure systems are in place for up load of retrospective data to open Exeter	Investigate other PCT areas methods of up loading data	Priority 1	Commenced up loading data	
8.4	HPV-Ensure seamless transition from use of cervarix to Gardasil in September 2012	Re establish HPV sub group meetings to determine current training needs.	Priority 2		
8.5	BCG- establish current contract arrangements	Develop links with acute respiratory teams	Priority 2		

Objective 9: Develop an internal and external communication plan, paying particular attention to community engagement and a social marketing initiatives

	Objective	Action	Priority	RAG rating/progress	Lead
9.1	Improve communication around current immunisation programmes with health professionals within primary care, acute trusts and community settings.	The Immunisation Co-ordinator and public health team will work with the communications department and partners to promote immunisations through various community groups at a local level.	P2		
9.2	Improve communication around current immunisation programmes with the public.	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation.	P2		
9.3	Engage communities in the development or change to current immunization programmes through social marketing initiatives	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation. Work to publicise immunisation issues through media events and campaigns.	P2		

Objective 10: Horizon scanning to identify risks and trends in population demographics, and identify new vaccine developments to enable workforce and service delivery planning.

	Objective	Action	Priority	RAG rating/progress	Who should take action
10.1	Ensure Service providers are aware of possible future changes to immunisation schedules and capacity issues	Keep abreast of JCVI meetings and current research into possible need for booster vaccinations in specific age groups Develop links with the Health Protection Agency to update on local and national infectious disease issues.	P3 P3	Ongoing	PH
10.2	Ensure public are given appropriate information and awareness on new emerging vaccines and vaccine programmes	Engage with relevant community and voluntary services and the general public to enhance knowledge and understanding of immunisation. Work to publicise immunisation issues through media events and campaigns.	P3		
10.3					

References

Department of Health 2006 Immunisation against infectious disease D Salisbury, M Ramsay, K Noakes
Department of Health 2005 Vaccination services: Reducing inequalities in uptake
Department of Health 2004 Choosing Health: Making healthy choices easier
Department of Health 2005 Vaccination services reducing inequalities in uptake
Department of Health 2008 Operational Plans2008/09 - 2010/11, (Implementing the 2008/09 Operating Framework) National Planning Guidance and "vital signs"
Joint Committee for Immunisation and vaccination (JCVI) http://www.dh.gov.uk/ab/JCVI/index.htm

Appendix 1. Local Cover data 2010/11

12 month cohort

		DTaP/IPV/HiB	Men C	PCV
Eligible	*n*	12,243	12,243	12,243
Immunised	*n*	11,527	11,449	11,469
	%	94.2%	93.5%	93.7%

24 month cohort

		DTaP/IPV/HiB	MMR	Men C	HiB/Men C	PCV
Eligible	*n*	11,998	11,998	11,998	11,998	11,998
Immunised	*n*	11,545	10,705	11,521	11,025	11,154
	%	96.2%	89.2%	96.0%	91.9%	93.0%

5 year cohort

		DT/Pol	Pertussis	HiB	MMR	Men C	PCV
		Primary	*Primary*	*Infant*	*1st dose*	*Infant*	*Infant*
Eligible	*n*	11,719	11,719	11,719	11,719	11,719	
Immunised	*n*	11,326	11,334	11,300	11,145	11,304	
	%	96.6%	96.7%	96.4%	95.1%	96.5%	

		DTaP/IPV	HiB/Men C	MMR	PCV
		Booster	*Booster*	*2nd dose*	*Booster*
Eligible	*n*	11,719	4,952	11,719	4,952
Immunised	*n*	10,632	3,636	10,485	3,954
	%	90.7%	73.4%	89.5%	79.8%
			*		*

** Due to scheduling parameters, data for Hib/Men C and PCV for the 5 year cohorts was only collected for the last 2 quarters*

HEALTH SCRUTINY FORUM

7 February 2013

Report of: Scrutiny Support Officer

Subject: HEALTH REFORMS - COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To inform Members that the Chief Officer Designate from NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group and the Director of Operations and Delivery from the Durham, Darlington and Tees Area Team will be in attendance at today's meeting to discuss the health reforms.

2. BACKGROUND INFORMATION

2.1 The Chief Officer Designate from NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group and the Director of Operations and Delivery from the Durham, Darlington and Tees Area Team will be in attendance at today's meeting to outline the roles, responsibilities and structures of the Clinical Commissioning Group and the Local Area Team.

2.2 A briefing on the Health and Social Care Act 2012 is attached as **Appendix A** for Members information.

3. RECOMMENDATION

3.1 It is recommended that the Members of the Health Scrutiny Forum consider the information presented at this meeting and seek clarification on any relevant issues where required.

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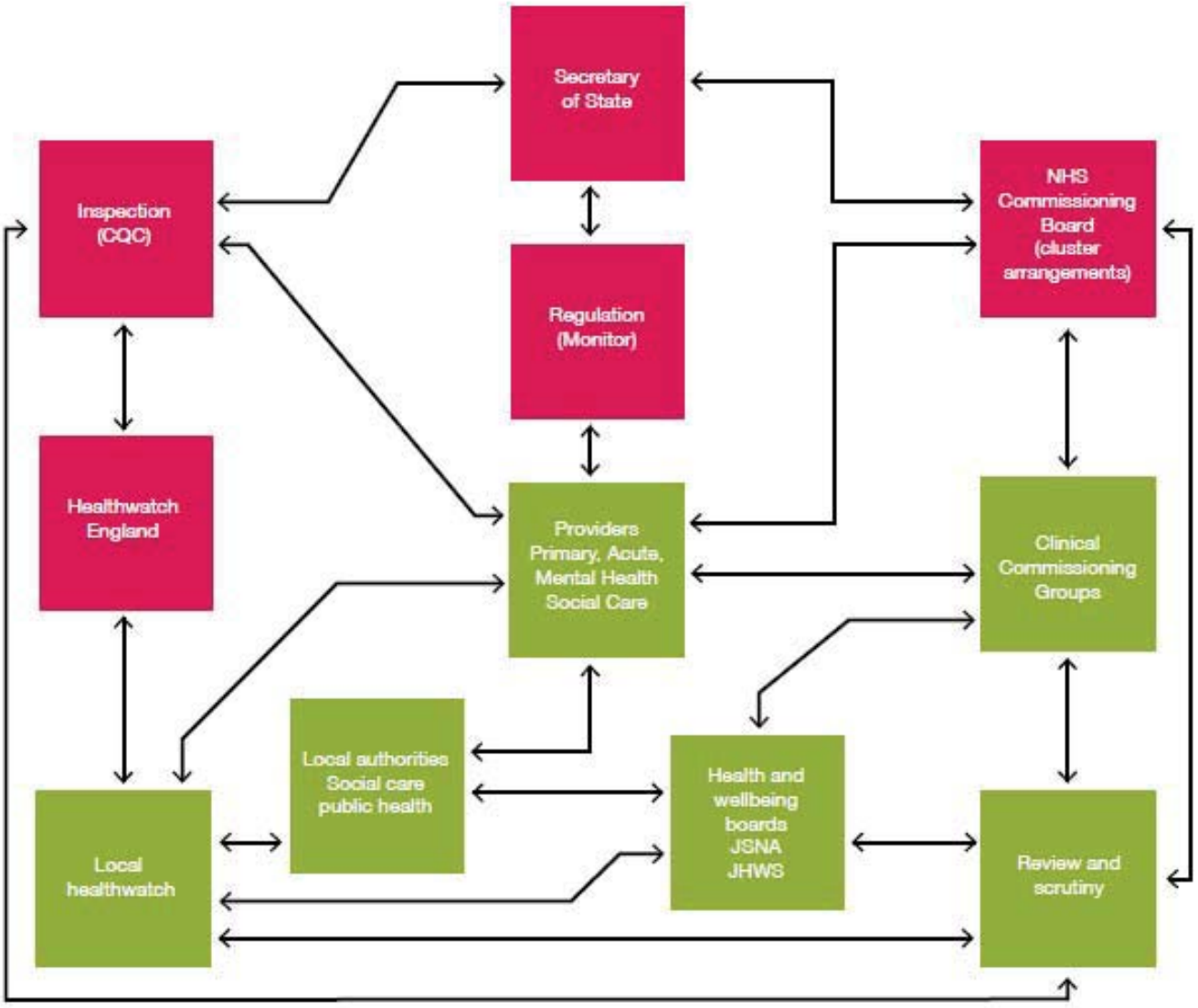
BACKGROUND PAPERS

No background papers were used in the preparation of this report.

Health and Social Care Act 2012

Briefing for overview and scrutiny members and officers

cfps Centre for Public Scrutiny
accountability, transparency, involvement



June 2012

Health and Social Care Act 2012

Briefing for overview and scrutiny members and officers

cfps Centre for Public Scrutiny
accountability, transparency, involvement

Introduction

At over 450 pages in length the Health and Social Care Act 2012 is both long and complicated. The Act legislates for the NHS reforms first set out in the white paper *Equity and Excellence: Liberating the NHS*, which was published in July 2010. The Act, which received Royal Assent on 27 March 2012, now defines the core of the Government's proposals in primary legislation. A considerable amount of secondary legislation, regulations and further guidance is expected, providing detail on how the new Act will work in practice once the major provisions come in to force in April 2013.

CfPS commented on the proposed changes throughout the consultation process and passage of the Bill. The Centre is pleased with the continuing commitment to independent council scrutiny. Building on this, scrutiny of health by principal councils must focus on and strengthen the leadership role of councils and elected councillors. Scrutiny has a clear role at every stage of the commissioning cycle, from needs assessment through commissioning to service delivery and evaluation of health outcomes. These roles should be communicated widely to local authorities, NHS organisations and associated providers and to the wider public.

Scrutiny should maintain a strategic overview whilst not losing sight of what is happening on the ground. It is important to ensure that scrutiny is able to look across the health and social care interface and keep focused on the quality of care. Scrutiny's role in this is particularly valuable to the regulators, especially the Care Quality Commission.

CfPS and practitioners have been involved in forming recommendations for inclusion within the scrutiny regulations that will follow later this year. There is consensus that any new regulations must reflect the principles of effective health overview and scrutiny that have developed in response to previous legislation. What works well in the current regulations must not be lost.

This briefing is in two sections:

- ☑ Section one – summarises the parts of the Act.
- ☑ Section two – provides commentary on the main features within the Act and its implementation timescale.

Section one – a summary of the parts of the Act

The Health and Social Care Act 2012 is in 12 parts. The summary below is taken from the explanatory notes on www.legislation.gov.uk.

Part 1 sets out a framework in which functions in relation to the health service are conferred directly on the organisations responsible for exercising them. The Secretary of State (SoS) will continue to be under a duty to promote a comprehensive health service. Part one also establishes a new non-departmental public body, the NHS Commissioning Board (NHSCB). It also makes provision for the establishment of Clinical Commissioning Groups (CCGs) and contains measures relating to the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs).

Part 2 contains provisions relating to the public health service, including the abolition of the Health Protection Agency (HPA), functions in relation to biological substances and radiation protection,

the repeal of the AIDS (Control) Act 1987 and co-operation with bodies exercising functions in relation to public health.

Part 3 sets out provisions for regulation of health and adult care services in England and defines the role of Monitor, the sector regulator.

Part 4 amends Chapter 5 of Part 2 of the NHS Act 2006, which makes provision for NHS foundation trusts, removing various restrictions on foundation trusts and their authorisation, preventing them from being returned to NHS trust status and setting out Monitor's role in relation to arrangements in respect of failing trusts. It sets out new arrangements for governance, financing and accounting of foundation trusts.

Part 5 provides for the creation of a new national body, Healthwatch England (HWE), to be established as a statutory committee within the Care Quality Commission (CQC). It also makes provision about local Healthwatch (LH) organisations in each local authority area. Part 5 also deals with the health scrutiny functions of local authorities and makes provision for the establishment of health and wellbeing boards (HWBs) in each upper tier local authority area, setting out their role. It also provides for foundation trusts and CCGs to be designated as Care Trusts and removes certain restrictions on those to whom the Health Service Ombudsman can report.

Part 6 amends the NHS Act in relation to medical, dental, ophthalmic and pharmaceutical services following the creation of the NHSCB, CCGs and the public health service.

Part 7 makes changes to the regulation of health and social care workers, abolishing the General Social Care Council (GSCC) and transferring some of its functions to the Health Professions Council (HPC). It also abolishes the Office of the Health Professions Adjudicator (OHPA).

Part 8 re-establishes the National Institute for Health and Care Excellence (NICE) as a non-departmental public body and sets out aspects of its role.

Part 9 relates to the publication of information standards and the collection of information from providers of health and social care services.

Part 10 abolishes the Alcohol Education and Research Council, the Appointments Commission, the National Information Governance Board for Health and Social Care, the National Patient Safety Agency and the NHS Institute for Innovation and Improvement.

Part 11 contains miscellaneous provisions, including duties for bodies to co-operate, arrangements with devolved authorities, supervised community treatment and transfer schemes.

Part 12 covers technical matters, including regulatory powers and commencement matters.

Section two – main features within the Health and Social Care Act

Below is a summary of the main features of the Health and Social Care Act – it is comprehensive but highlights the key areas. It covers:

- ☑ Health scrutiny
- ☑ The duties of the Secretary of State
- ☑ Integration
- ☑ Commissioning
- ☑ Public Health
- ☑ Patient Involvement - Healthwatch (nationally and locally)
- ☑ Regulation
- ☑ Foundation Trusts

HEALTH SCRUTINY – Part 5, Sections 190-192

The Act confers health scrutiny powers to upper tier local authorities themselves. They may still choose to continue to operate their existing health overview and scrutiny committees. They may also choose to put in place other arrangements.

The current powers relating to consultation on services changes, requesting information, requesting attendance at meetings to answer questions and responses to reports and recommendations will be conferred by regulations on local authorities as a whole and the complementary duties will be extended to all commissioners and providers of NHS services.

Timescale:

- ☑ *Health scrutiny powers move to upper tier local authorities and extended to all commissioners and providers of NHS services April 2013.*

DUTIES OF THE SECRETARY OF STATE – Part 1

The SoS will be responsible for promoting a comprehensive health service, and will retain ultimate accountability for securing the provision of services rather than securing services directly. The SoS will exercise this duty through his relationship with NHS bodies to be established through the Act (for example the NHS Commissioning Board) by way of a Mandate. The Act introduces a new duty to reduce health inequalities. The SoS also has powers of intervention in relation to failure by various bodies connected with the health service.

Timescale: Effective April 2013.

INTEGRATION

Health and wellbeing boards – Part 5

Statutory **health and wellbeing boards** (HWBs) are established by section 194 of the Act as committees of upper tier and unitary councils. They will bring together locally elected councillors and commissioners including clinical commissioning groups, directors of public health, children's

services and adult social care and local Healthwatch. HWBs will assess local needs (and publish a Joint Strategic Needs Assessment (JSNA)) and develop a shared strategy (and publish a Joint Health and Wellbeing Strategy (JHWS)) to address them, providing a strategic framework that health and social care commissioners must have regard to. The NHS Commissioning Board will also be able to be represented on boards when appropriate issues are discussed.

There is also the power for the local authority to delegate any of its powers to the HWB with the exception of health scrutiny – this remains independent.

HWBs will be able (but not required) to bring together a wider range of partners including those delivering 'health related services' and consider how they may be better integrated with health and social care. It will be important to establish how schools and higher education, employers and criminal justice will be included.

Timescale:

- ☑ *Shadow arrangements mostly in place during 2012.*
- ☑ *JSNAs and JHWS will need to be in place by October 2012 to inform commissioning plans for 2013 – 14.*
- ☑ *Requirement to have a statutorily operational board by April 2013.*

COMMISSIONING – Part 1

The **NHS Commissioning Board** and **Clinical Commissioning Groups** will be subject to a 'duty to promote integrated health, social care and 'health related services' around the needs of service users'. They will also be encouraged to have strong relationships with a 'range of health and care partners'.

The **NHS Commissioning Board** (NHSCB) will be the national commissioning body. It will be structured around the five outcome domains in the NHS Outcomes Framework, with national professional leads for each outcome area. The NHSCBs key roles will be to authorise local Clinical Commissioning Groups (CCGs) to operate, allocate their funding and hold them to account for their outcomes, and to directly commission some services such as primary care and specialised services. Where CCGs are not authorised to operate from April 2013 the NHSCB will commission services on behalf of local areas.

The NHSCB will be supported by Clinical Networks, which will advise on single areas of care such as cancer, and Clinical Senates, which will take an overview of local health and healthcare for local populations and provide multi-professional advice on local commissioning plans.

Clinical networks and senates' advice and support will help the NHSCB and CCGs to improve the design and delivery of better patient care.

The Board will be accountable to the Secretary of State for meeting the requirements outlined in the Mandate. The Mandate will be subject to consultation, publication and consideration in Parliament.

During the transitional period up to April 2013, the Board (acting as a special health authority) is working with Strategic Heath Authorities and Primary Care Trusts to develop an operational configuration. SHAs and PCTs retain their statutory responsibilities until April 2013.

Timescales: The NHS Commissioning Board will:

- ☑ *Be established as a Special Health Authority during 2012.*
- ☑ *Begin to carry out the authorisation of CCGs from October 2012 to ensure that local commissioning can take place from April 2013.*
- ☑ *Take on its full statutory role from April 2013.*

Clinical Networks will improve the design and delivery of better patient care by advising Commissioning Groups about particular pathways or conditions, such as cancer care.

There are already national clinical networks: groups of experts, including patient and carer representatives, brought together around particular pathways or conditions. The Government proposes to retain and strengthen these networks so that they cover many more areas of specialist care. Networks will provide strong clinical leadership in specialist areas, such as care for vulnerable groups and those with less common conditions.

Timescale: In line with the development of the NHSCB.

Clinical Senates - A range of professionals will be brought together in local clinical senates to take an overview of health and healthcare for local populations and provide a source of expert support and advice on how different services fit together to provide the best overall care and outcomes for patients.

Clinical senates will provide advice and support on a range of issues, and from a variety of health and care perspectives, including those of professionals who sometimes go unheard, such as allied health professionals.

Timescale:

- ☑ *In line with the development of the NHSCB.*

Clinical Commissioning Groups (CCGs) will have responsibility for local commissioning, and will be GP led through general practices – replacing Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) that will be abolished in April 2013. CCGs will have a duty to promote integrated health and social care around the needs of service users. CCGs will have to have regard to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed through HWBs when commissioning care.

CCGs must have a governing body to ensure that the group has made appropriate arrangements and that it complies with its obligations and duties as to effectiveness and efficiency.

To be fully operational a CCG will need to be authorised by the NHS Commissioning Board subject to certain criteria (e.g. that it has the means to undertake commissioning responsibilities; an

accountable officer; a governing body with lay and wider clinical membership; a constitution which outlines processes for decision-making, accountability and dealing with any conflicts of interest).

The Act introduces a 'quality reward' intended to recognise CCGs and practices within it in order to incentivise high-quality commissioning. Details of this reward will be clarified in secondary legislation.

Timescale:

- ☑ *CCGs (under delegation from PCTs) produce commissioning plans for 2013/14 by October 2012.*
- ☑ *PCTs and SHAs will be abolished in April 2013.*
- ☑ *CCGs fully operational having received authorisation by April 2013.*

PUBLIC HEALTH – Part 2

The Act restructures public health services nationally and locally.

Locally, from April 2013 the transfer of public health from the NHS to local authorities is accompanied by new powers for local authorities to commission and provide public health services. They will take over most of the public health functions currently carried out by PCTs. This work will be led by **Directors of Public Health** and funded through a ringfenced public health grant. Directors of Public Health have been added to the list of statutory chief officers in the *Local Government and Housing Act 1989* to establish parity with other chief officers who report to the Head of the Paid Service.

Some public health functions will remain within the NHS. Directors of Public Health will be supported by Public Health England who will develop the workforce and build the national evidence base.

Nationally, the Act places a duty on the Secretary of State to protect the people of England, with central responsibility for health protection and response to emergencies. Although not mentioned in the Act, a new executive agency, **Public Health England**, will be the national body overseeing the public health system and will be accountable to the Secretary of State.

From its establishment in April 2013, **Public Health England** (PHE) will be the authoritative national voice and expert service provider for public health, providing expert evidence and intelligence, and the cost-benefit analysis that will enable local government, the NHS, and the voluntary, community and social enterprise sector to protect the public by providing a comprehensive range of health protection services ensuring that the needs of different groups are met.

PHE will work with partners across the public health system and in wider society to:

- ☑ Deliver, support and enable improvements in health and wellbeing in the areas set out in the Public Health Outcomes Framework
- ☑ Lead on the design, delivery and maintenance of systems to protect the population against existing and future threats to health.

Timescale:

- ☑ *Transfer of Public Health function to Local Authorities - April 2013*
- ☑ Abolishment of PCTs – April 2013.
- ☑ Public Health England established April 2013

PATIENT INVOLVEMENT

The Government plans to strengthen the collective voice of patients and carers in the system at both a local and national level. Involvement arrangements at a local level will evolve to ensure a smooth transition from the existing Local Involvement Networks to the new Healthwatch arrangements, creating a strong local infrastructure, and at a national level **HealthWatch England** will be established as an independent patient champion within the Care Quality Commission.

Under the new arrangements patients and the public will influence the rest of the health system as follows:

- ☑ The NHS Commissioning Board will have a national director-level role with responsibility for patient and public engagement.
- ☑ There will be a new requirement for the Care Quality Commission to respond to advice from its HealthWatch England subcommittee.
- ☑ There will be a requirement on the Secretary of State to consult HealthWatch England on the mandate to the NHS Commissioning Board.
- ☑ There will be a duty on Monitor to carry out appropriate public and patient involvement in the exercise of its functions.
- ☑ There will be an explicit requirement that local HealthWatch membership is representative of different users, including carers.
- ☑ HWBs will have a new duty to involve users and the public.
- ☑ Clinical commissioning groups will have to set out in their annual commissioning plans how they intend to involve patients and the public in their commissioning decisions.
- ☑ Clinical commissioning groups will be required to consult on their annual commissioning plans to ensure proper opportunities for public input.
- ☑ Clinical commissioning groups will have to involve the public on any changes that affect patient services, not just those with a “significant” impact. This point will also apply to the NHS Commissioning Board.
- ☑ The NHS Commissioning Board will assess how effectively clinical commissioning groups have discharged their duty to involve patients and the public as part of their annual assessment.
- ☑ Commissioners and providers will have a duty to have due regard to findings from local HealthWatch organisations.

HEALTHWATCH – Part 5

The Act provides for the creation of a new national body, **Healthwatch England**, as a committee of the Care Quality Commission. **Local Healthwatch** organisations, for which Healthwatch England will set standards, will have statutory duties and powers similar to those of Local Involvement Networks but with some additional functions relating to provision of information about

health and care services and complaints advocacy. Arrangements for local Healthwatch are to be commissioned by local authorities by April 2013.

☑ **Local Healthwatch (LHW)**

Upper tier and unitary local authorities have significant statutory responsibilities for setting up Local Healthwatch (which may include complaints advocacy) and monitoring their work. LHW will act as a point of contact for individuals, community groups and voluntary organisations when dealing with health and social care and will be a member of the Health and Wellbeing Board taking part in decisions that influence commissioning.

LHW will forward on to Healthwatch England views and feedback that it gathers from patients' and the public to help HWE carry out its role of influencing health and social care at a national level.

LHWs could be community interest companies, charities or social enterprises commissioned by the local authority to be the LHW for an area; or LHW could commission other organisations to carry out different aspects of their role. But local authorities will retain the duty to ensure the value of LHW arrangements.

Timescale:

☑ *local authorities begin commissioning process during 2012*
☑ *LHW commences April 2013.*

Healthwatch England (HWE)

HWE is established by section 161 of the Act as a statutory committee of the CQC, tasked with representing people using health and care services at a national level and will have a role in advising CQC to review services where appropriate.

Timescale:

☑ *HWE established October 2012.*

REGULATION – Part 3

The Act extends the powers of **Monitor** to become the economic regulator for all NHS funded services. The Act also provides for Monitor to regulate adult social care – however the detail to this is not yet known. Children's services will continue to be regulated by OFSTED.

All providers of NHS healthcare services, unless exempted by the Secretary of State will need to hold a licence with Monitor, which will maintain and publish a register of licence holders.

The **Care Quality Commission** (CQC) will continue to act as the quality inspectorate across health and social care. The Act removes the CQC's responsibility for assessing the performance of NHS commissioners, as this will be taken on by the NHS Commissioning Board, and for carrying out periodic reviews of NHS services. This should allow the CQC to focus its resources on its core

role of registering and regulating providers. The Act requires Monitor and the CQC to co-operate and share information and establish a joint registration system / process. The CQC will also take over the role in regulating the collection and provision of information.

The Government says that the CQC's remit is different from Monitor in that it will:

- Focus will on quality.
- Register health and adult social care services to ensure quality standards and maintains inspections to make sure those standards continue to be met.

CQC will:

- Be responsible for licensing NHS and adult social care providers against essential safety and quality requirements.
- Continue to inspect providers against the essential levels of safety and quality.
- Carry out inspections in response to information that it receives about a provider, which will now come through *CCGs, local Healthwatch* and *Healthwatch England*, as well as the already established channels, such as council scrutiny; patient and service user feedback and complaints.
- Establish Healthwatch England as a committee of the CQC

The **National Institute for Health and Care Excellence** (NICE) will retain its role in developing quality standards for the NHS, public health and social care. The legislation has provided for the change of name to this substituting Clinical for Care.

Timescale:

☑ Exact details on the implementation timescales for Monitor and the CQC are not known at the time of publication. However this is likely to be in line with other changes – April 2013.
☑ From 2013/14, price-setting is the joint responsibility of the NHS Commissioning Board and Monitor

FOUNDATION TRUSTS – Part 4

Trusts are no longer required to become *Foundation Trusts* (FTs) by April 2014; however there is an expectation by the Department of Health that the vast majority of NHS Trusts will be FTs by that date. The Act:

- Allows for the Secretary of State to bring in the provision to abolish all remaining NHS Trusts at a future date.
- Exempts trusts that have entered into 'franchise arrangements' from having to achieve FT status for the duration of those arrangements, and for three years after the arrangements have ended.
- Gives FTs greater scope to generate private income although they will have to ensure that the majority of their income is through NHS services.

The *NHS Trust Development Authority* (which does not appear in the Act) is to be established in summer 2012. The Government says that the Authority will 'provide governance and oversight of NHS Trusts following the abolition of SHAs in 2013.' Included in its remit is:

- Performance management of NHS Trusts,
- Financial scrutiny and powers of intervention if NHS Trusts are deemed to be poorly performing.

Timescale:

☑ *The date of April 2014 was removed but DH expects the majority to be FTs by that date*

SUMMARY AND COMMENTS

The 15 month passage of the Bill saw many refinements to the content of the Bill, however we now have certainty of the structures that we will be working with and the dates that they will be coming in to being.

The bulk of the provisions remain to be brought in to force, with a considerable amount of secondary legislation, regulations and further guidance expected providing detail on how the Act will work in practice.

In practice the changes for most of the areas covered by the Act were underway in many areas prior to the legislation going through. Councillors and officers are wrestling to keep up and differentiate between what must be done and what they can do in the absence of the regulations. However it is important to recognise that there is a lot of good practice being generated and a great deal of pathfinder experience to assist you.

CfPS has also produced useful guides to help you to see your way through the changes. These include:

☑ Health overview and scrutiny: Exploiting opportunities at a time of change
☑ Accountability and the new structures
☑ Achieving an effective health and wellbeing board
☑ 10 questions to ask around arrangements for local Healthwatch
☑ Smoothing the way – developing local Healthwatch through learning from LINks

The reforms present an opportunity to redefine relationships between clinicians, other professionals, people who use services and communities. Reducing central control; focusing on outcomes; increasing patient and public influence; improving people's health – all of these have potential to create the right environment for local solutions to emerge for local health and care challenges.

CfPS has demonstrated that the reforms provide an opportunity for councillors to consider how they can best establish relationships in the new environment and how they can best go about their work in relation to commissioning (through the NHS Commissioning Board and clinical commissioning groups) and stimulating healthcare, social care and health improvement together with health and wellbeing boards.

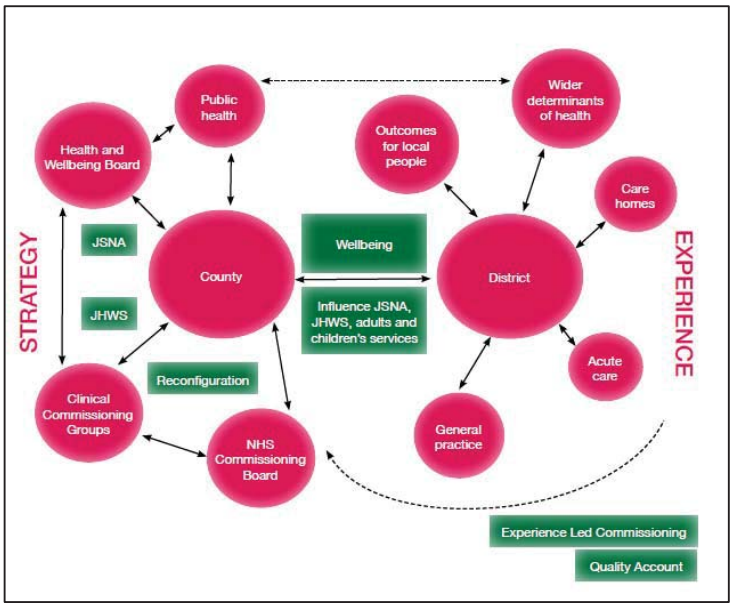
Health and Social Care Act 2012

Briefing for overview and scrutiny members and officers

Centre for Public Scrutiny
accountability, transparency, involvement

During this transition period up to April 2013 council scrutiny has a great opportunity to play a leading role in bringing people together to design ways of working for the future. The new health and social care architecture provides the opportunity for areas to get things right – the right people, the right information, and the right systems and services. Ensuring that the new architecture is effective, accountable, transparent and inclusive will help to provide a strong and sustainable health and social care system for future generations, and one that is integrated with social care and public health improvement activities.

Included in this new way of working could be the role of 'layered scrutiny' - better co-ordination of the scrutiny function within two-tier areas. County and district councils have different service responsibilities, but both have a significant impact on health and wellbeing – county councils through their responsibility for education, social care and their new public health role; and district councils through their responsibilities for social housing, planning and economic development. The scale and pace of the health reforms, together with reducing resources to support council scrutiny, requires a fundamental rethink of the way scrutiny works and agreement locally about who is best placed to scrutinise different aspects of the new healthcare and social care landscape – for example commissioning services; providing services; and tackling inequalities. There are still some issues to be clarified through regulations that are due out for consultation in the summer. CfPS has facilitated local scrutiny committees contributing to the thoughts on the content of the regulations. This diagram shows how scrutiny of health services could look in a two-tier area.



Note – arrangements for council scrutiny of social care services are now covered by council's general arrangements for scrutiny under the Local Government Act 2000 (as amended by the Localism Act 2011). See our guide Pulling it all Together for more detail.

CfPS

June 2012

NHS Tees

Rollout of NHS 111

Briefing for Overview and Scrutiny Committee

December 2012

Introduction

This briefing outlines the forth-coming roll-out of the NHS 111 service across the NHS Tees area. NHS 111 is a new national telephone service for when the call is less urgent than 999.

Background

The North East was the first area in the country to pilot NHS 111 and is firmly on track to provide the first regional roll-out of this new service.

NHS 111 will make it easier for the public to access local health services and will drive improvements in the way in which the NHS delivers that care. The service is part of the Government's wider revisions to the urgent care system to deliver a 24/7 urgent care service that ensures people receive the right care, from the right person, in the right place, at the right time.

The coalition Government has stated that NHS 111 is a "mission critical" policy and should be in place across England by October 2013.

Process

NHS 111 was launched in County Durham and Darlington as a pilot on 23 August 2010. Since then the service has been well received with an average of 4,345 calls per week.

NHS 111 will officially go live in County Durham and Darlington and South of Tyne and Wear in December 2012, followed by the North of Tyne and Tees on 2 April 2013.

In January this year the North East Ambulance Service NHS Foundation Trust was awarded the contract to handle 111 and the service is now set to roll-out across the region.

In preparation, the NHS 111 North East Clinical Governance submission, which will demonstrate that the service is safe for patients to use and ready for implementation, was submitted to the Department of Health on 25 October 2012, with a Clinical Review taking place on 20 November 2012.

Impact of the Proposal

The ultimate aim of the NHS 111 service is to facilitate patients' access to the most appropriate health service at any time of the day or night.

In County Durham and Darlington the service has been well received. Key statistics include:

- Average length of call is under 6 minutes;
- 18% calls are dealt with within 111 service;
- 4.5% calls referred to A&E;
- 42% of callers booked directly into an appointment which will meet their health need.

Research undertaken by the University of Durham to review the experience of patients, carers and families who had used the NHS 111 service in County Durham and Darlington demonstrated that the majority of callers reported a really positive experience of the North East NHS 111 service.

A translation service will be in place for those callers whose first or preferred language is not English.

Communication and Engagement

The NHS 111 North East Programme Team is working very closely with local GPs, nurses, pharmacists and other healthcare providers to ensure the service which is rolled out is most appropriate to the local population. Emerging Clinical Commissioning Groups in the area are also integrally involved to ensure that the NHS 111 service continues to be safe and effective.

The North East Clinical Lead for NHS 111 is Dr Kat Noble, who provides clinical leadership and support for 111 and urgent care services and represents the views of North East clinicians at a local, regional and national level.

Dr Noble is supported by a team of clinical leads who work at a local level to ensure the NHS 111 service adds value to the urgent care patient pathway in their area. Their role includes clinical and stakeholder engagement and clinical scrutiny of the systems and processes involved, through peer assurance.

A programme of communications and marketing activity aimed at raising awareness and understanding of the service with the public will take place in each area once the service is live. This will be supported by a Department of Health media campaign in the weeks after the launch.

Action for Overview and Scrutiny

Overview and Scrutiny are asked to note the content of this briefing and highlight any additional issues that they feel may need addressing in informing and involving the local community and how they wish to be involved.

1.1 Vision

NHS 111 TRANSFORMING ACCESS TO URGENT HEALTHCARE

The NHS 111 service will make it easier for the public to access urgent healthcare and will drive improvements in the way in which the NHS delivers that care.

1.2 Public Top Lines

What is it?

- NHS 111 is a new telephone service being introduced to make it easier for you to access local health services, when you have an urgent need.
- If you need to contact the NHS for urgent care there are only three numbers to know; 999 for life-threatening emergencies; your GP surgery; or 111.
- When you call 111 you will be assessed, given advice and directed straightaway to the local service that can help you best – that could be an out-of-hours doctor, walk-in centre or urgent care centre, community nurse, emergency dentist or late opening chemist.
- NHS 111 is available 24 hours a day, 365 days a year. Calls from landlines and mobile phones are free.
- NHS 111 is currently available in County Durham and Darlington, Nottingham City, Lincolnshire, Luton, the Isle of Wight, North Derbyshire and Derby City, Lancashire (excluding West Lancashire), and the London Boroughs of Croydon, Hillingdon, Kensington and Chelsea, Hammersmith and Fulham, and Westminster.

How does it work?

- 111 will get you through to a team of fully trained call advisers, who are supported by experienced nurses. They will ask you questions to assess your symptoms, and give you the healthcare advice you need or direct you to the right local service.
- The NHS 111 team will where possible book you an appointment or transfer you directly to the people you need to speak to. If they think you need an ambulance, one will be sent just as quickly if you had dialled 999.

When do you use it?

- You should call 111 if:
  - you need medical help fast, but it's not a 999 emergency;
  - you don't know who to call for medical help or you don't have a GP to call;
  - you think you need to go to A&E or another NHS urgent care service; or
  - you require health information or reassurance about what to do next.

Why should you use it?

- When you need health care urgently NHS 111 will direct you straightaway to the local service that can help you best.
- NHS 111 can help us take the pressure off the 999 service and local A&E departments, so that they can focus on emergency cases.

1.3 Stakeholder Top Lines

- NHS 111 will make it easier for the public to access local health services when they need help quickly. In future if people need to contact the NHS for urgent care there will only be three numbers; 999 for life-threatening emergencies; their GP surgery; or 111.
- The introduction of the NHS 111 service is part of the wider revisions to urgent care system to deliver a 24/7 urgent care service that ensures people receive the right care, from the right person, in the right place, at the right time.
- The NHS 111 service will be available 24 hours a day, 365 days a year, via the new free to call, easy to remember three-digit number.
- NHS 111 will provide a clinical assessment at the first point of contact, without the need to call patients back; will direct people to the right NHS service, first time, without the need for them to be re-triaged; and will be able to transfer clinical assessment data to other providers and book appointments for patients where appropriate.
- NHS 111 will work alongside the 999 emergency service and will be able to despatch an ambulance without delay and without the need for the patient to repeat any information.
- We expect the introduction of the NHS 111 service to:
  - Improve public access to urgent healthcare services;
  - Increase the efficiency of the NHS by ensuring that people are able to quickly and easily access the healthcare services they need;
  - Increase public satisfaction and confidence in the NHS;

  - Enable the commissioning of more effective and productive healthcare services that are tuned to meet peoples' needs; and to
  - Increase the efficiency of the 999 emergency ambulance service by reducing non-emergency calls to 999.
- NHS 111 is currently available in County Durham and Darlington, Nottingham City, Lincolnshire, Luton, the Isle of Wight, North Derbyshire and Derby City, Lancashire (excluding West Lancashire), and the London Boroughs of Croydon, Hillingdon, Kensington and Chelsea, Hammersmith and Fulham, and Westminster.

1.4 Benefits

The introduction of the new NHS 111 service is expected to provide key benefits to the public and the NHS, by:

- Improving the public's access to urgent healthcare services:
  - Providing a simple, free to call, easy to remember three-digit number, that is available 24 hours a day, 365 days a year; and
  - Directing people to the local service that is best able to meet their needs, taking into account their location, the time of day of their call and the capacity of services.
- Increasing the efficiency of the NHS:
  - Providing clinical assessment that ensures people access the right service, first time;
  - Directing people to the service that is best able to meet their needs; and
  - Rationalisation of call handling.
- Increasing public satisfaction and confidence in the NHS:
  - Improving the public's access to urgent healthcare services:
  - Providing an entry point to the NHS that is focused on peoples' needs;
  - Enabling people to access the right service, first time; and
  - Increasing efficiency of the NHS by directing people to the service that is best able to meet their needs.
- Enabling the commissioning of more effective and productive healthcare services that are tuned to meet people's needs:
  - Identifying the services, which are currently over or under used;
  - Providing information on people's needs and the services they are directed to; and
  - Increasing understanding of the shape of demand for each service.
- Increasing the efficiency of the 999 emergency ambulance service:
  - Reducing the number of non-emergency calls received by 999; and
  - Reducing the number of avoidable ambulance journeys.

HEALTH SCRUTINY FORUM

7 February 2013

Report of: Scrutiny Support Officer

Subject: NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST – QUALITY ACCOUNT 2013/14 – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 To introduce representatives from North Tees and Hartlepool NHS Foundation Trust who will be in attendance at today's meeting to discuss the Trust's Quality Account for 2013/14.

2. BACKGROUND INFORMATION

2.1 In November 2009 the Government published the Health Bill which required all providers of NHS healthcare services to provide an annual Quality Account. The Department of Health made a legal requirement on all NHS healthcare providers to send their Quality Account to an Overview and Scrutiny Committee in the local authority area where the provider has a registered office.

2.2 Members of the Health Scrutiny Forum met on 20 September 2012 where initial discussions were held in relation to the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2013/14.

2.3 At the meeting of the Health Scrutiny Forum on 18 October 2012, Members agreed three key priorities to be forwarded to the Director of Nursing and Patient Safety at North Tees and Hartlepool NHS Foundation Trust for consideration in the Trust's Quality Account 2013/14 as detailed below:-

(i) End of Life Care:
Support patients approaching end of life and their families. Make it possible for patients to die at home, if that is their wish. Ensure that the Oasis Suite is continued, as it is a facility that will make such a difference to families in difficult times.

(ii) Nutrition:
Offer nutritional meals to patients, and provide patients with a variety of choice and their meals at the time that best suits them.

(iii) Access to Hospital Sites:
Access finance to assist with transport to current hospital sites.
Consider the experiences of patients and visitors who travel to the hospital to improve access.

2.4 Subsequently, representatives from North Tees and Hartlepool NHS Foundation Trust will be present at today's meeting to provide a presentation in relation to North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2013/14.

3. RECOMMENDATIONS

3.1 That Members:-

(i) Note the content of this report and the presentation, seeking clarification on any issues from the representatives from North Tees and Hartlepool NHS Foundation Trust present at today's meeting; and

(ii) Formulate a response from the Health Scrutiny Forum to be included in the North Tees and Hartlepool NHS Foundation Trust's Quality Account for 2013/14.

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BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

(a) Minutes of the meetings of the Health Scrutiny Forum held on 20 September 2012 and 18 October 2012.

HEALTH SCRUTINY FORUM

7 February 2013

Report of: Director of Public Health

Subject: SCRUTINY INVESTIGATION IN THE TOPIC OF 'SEXUAL HEALTH' – ADDITIONAL INFORMATION: APAUSE AND C-CARD

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide a response to the request for additional information made by the Forum, following the Health Scrutiny Forum meeting on 10th January 2013.

2. BACKGROUND INFORMATION

2.1 Members will recall that at the meeting on 10th January 2013, Members requested further information regarding the APAUSE (Added Power and Understanding in Sex Education) sex and relationship programme and the C-Card scheme.

3. APAUSE

3.1 The APAUSE programme was delivered in Hartlepool secondary schools from 1997-2009/10. The programme ran in 3 secondary schools (Manor, Brierton and HighTunstall) initially and the final 3 schools came on board by 2000/01. The programme was funded by, the then strategic health authority, Tees Health.

3.2 The aims of APAUSE are to promote the positive aspects of relationships, both emotional and physical and the objectives are to:

- Increase tolerance, respect and mutual understanding
- Enhance knowledge of risks and counteracting myths
- Improve effective contraceptive use by teenagers who are already sexually active
- Provide effective skills to those who wish to resist unwelcome pressure

3.3 Three sessions are delivered in Year 9 and 10 by teachers and health professionals or others. Trained peer educators (aged 16 – 19 years) deliver a further 4 sessions with Year 9 students with trained staff in the classroom but not directly participating in deliver. All staff delivering the programme undertake 2 days APAUSE training. Peer educators also undertake specialised training to deliver the programme.

3.4 The cost of delivering the programme includes £8,500 for the training, class room materials and evaluation; this is based on 2009 costs. There would also be the cost for an APAUSE Co-ordinator (£26,000 + on costs) who would work with the schools and health professionals to organise the delivery of the programme and undertake the training function.

3.5 The challenges of delivering the programme include:

- Cost of purchasing the programme
- Schools deliver PSHE (Personal, Social, Health Education) in different ways e.g. 1 hour lessons, 15 minutes in tutor groups, 'Discovery Days'
- Capacity within School Nursing Service
- Cost of commissioning 'others' to deliver

3.6 Benefits of delivering the programme include:

- A co-ordinated approach to delivery
- Evidence based programme utilising team teaching and peer education methods
- Designated role to support the schools in the training, planning and delivery of sex and relationship education.

3.7 Please refer to appendix 1 for trends in under 18 conceptions whilst the programme was delivered compared to when it ceased.

4. BUMPY RIDES ~ RISK & RISILIANCE PROGRAMME

4.1 Schools are currently offered a web based resource 'Bumpy Rides' which offers a holistic risk and resilience curriculum for Years 7 – 10. This includes:

- Sex and relationship education
- Substance misuse including alcohol, drugs and smoking
- Emotional health and wellbeing

4.2 Schools are able to use the whole programme to deliver their PSHE curriculum or 'cherry pick' the most appropriate aspect that suits their school needs.

4.3 The programme has been designed so that teachers would be the main delivers of the programme. However it was acknowledge that schools would need support in delivering some of the more sensitive lessons. Contact

details of organisations that would support schools in the delivery of these lessons have been included on the website. It is the schools responsibility to contact the organisations for support.

4.4 There is no cost for this programme.

4.5 The challenges of delivering this programme are:

- No co-ordinated approach, therefore can appear fragmented
- Schools struggle to get outside agencies in to deliver in schools due to the time it takes to organise
- Students not able to acknowledge they have had 'Sex Education' as it is part of a 'Risk and Resilience' approach

4.6 Benefits of delivering the programme include:

- Sex Education is not seen in isolation and is taught in the wider context of 'risk'
- Schools are not wholly reliant on external agencies to deliver the programme.
- Schools are able to choose what they deliver and when so that it fits with the curriculum

5. C-CARD SCHEME

5.1 A condom distribution scheme has been in operation in Hartlepool since 2004; however that scheme evolved into a C-Card scheme in 2008. Assura are the current provided of the C-Card scheme the annual value of the contract is £7,500 for this they offer:

- Co-ordination and clinical input
- Resources including: condoms, lubricant, pregnancy testing kits, Chlamydia screening kits, C-Cards.
- Annual training and updates
- Support to C-Card sites
- Fast track referrals from sites into the sexual health service located within One Life

5.2 A C-Card scheme is a free and confidential service, providing free condoms, advice and information to young people. The scheme aims to make condoms more accessible to young people and to provide them with support and information about sexual health and how to use condoms correctly.

5.3 C-Cards operate on the basis that users are required to register with the scheme, a process which entails a consultation with a trained worker, before being issued with a C-Card. The C-Card is recognised in a number of outlets where young people can show their card and be given new supplies without further consultation, for a set number of visits ~ 10.

5.4 All C-Card schemes provide young people (13 – 25) with access to free condoms and lubricant, typically a pack will contain 6 – 10 condoms and a supply of lubricant, written instructions on the use and disposal of condoms and information on local sexual health services. In addition schemes offer additional services including pregnancy testing kits and chlamydia screening kits.

5.5 There are currently 45 sites (see appendix 2 for a list of sites) in Hartlepool and 119 youth workers/volunteers trained to deliver C-Card, the most active sites are the youth centres, one-stop-shop and headland future sites. There are in excess on 1,000 young people actively registered on the scheme.

6 SEXUAL HEALTH BUDGET

6.1 The annual budget for sexual health services is in the region of £800,000 this commissions a range of providers to deliver sexual health services across Hartlepool.

7. RECOMMENDATIONS

3.1 That Members of the Forum note the content of the report and where appropriate seek clarification.

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APPENDIX 1

Time Line

Sex and Relationship Education (SRE) Delivery Compared to Under 18 Conception Rates

Year	Under 18 Conception Rate	SRE Programme	C-Card Scheme
1997	74.8	APAUSE	
1998	75.6	APAUSE	
1999	81.2	APAUSE	
2000	57.4	APAUSE	
2001	61.8	APAUSE	
2002	55.9	APAUSE	
2003	68.2	APAUSE	
2004	64.1	APAUSE	√
2005	78.0	APAUSE	√
2006	64.5	APAUSE	√
2007	66.8	APAUSE	√
2008	66.1	APAUSE	√
2009	57.3	APAUSE	√
2010	55.5	Bumpy Rides	√
2011		Bumpy Rides	√
2012		Bumpy Rides	√

APPENDIX 2

The following groups provide condom distribution, chlamydia screening and pregnancy testing as part of the C-Card scheme in Hartlepool

Anna Court ~ supported housing for young parents
B76
Integrated Youth Support Service
DISC
Families First
Manor West
Manor Residents Association
Headland Future
Avondene flats
Scott Grange
Springboard
Young Person's Team
One Stop Shop
Youth Offending Team
Hartlepool Young Carers
Dyke House School
HYPED
Addvance into Nature
Greatham Youth Centre
Hartgables
Throston Youth Centre
Lynnfield Children's Centre
Rossmere Youth Centre
Brinkburn Youth Centre
Stranton Children's Centre
Mobile and Detached team
Wharton Annexe Youth Project
Manor College
College of FE
St Hilds School
Seaton Grange Youth Centre
NACRO
Connected Care
Solid Rock Café
Burbank Youth Centre
Pupil Referral Unit
High Tunstall School
St Paul's Project
Hart Training
Abbey Street (Headland future)
Central Estate (Headland Future)
Mires Avenue (Headland Future)
Disc Outreach
Child Services
Connected Care

ST HILD'S CHURCH OF ENGLAND SCHOOL

Students have one lesson a week, taught by non-specialist teachers. They study one Health module each year which lasts for one term.

The course content covers types of relationships, healthy lifestyles incorporating P.I.E.S. wellbeing and including risks associated with bad choices. STIs, STDs and issues surrounding pregnancy are included in the delivery.

The main resource used is 'Love & Sex Matters' published by the Salisbury Diocesan Board of Education. This is supplemented by resources from the 'Bumpy Rides' pack produced by Hartlepool LA Health coordinators.

We also buy in the services of 'Evaluate' who present to students in KS3 and offer excellent coverage of some of the more intimate aspects of SRE and the associated risks. Students are encouraged to make appointments with our school nurse if they wish to have private discussions and/or seek advice. We have attempted to involve the NHS Schools Team into our programme but this has not always been possible due to time restraints. A number of students use the community Health bus.

If you wish to obtain any statistical information please contact Mrs Judith Norman who is our lead Child Protection Officer.

Report of: **Councillor Christopher Akers-Belcher**
Councillor Stephen J Akers-Belcher
Councillor Marjorie James

Title: **Consultation findings Bournemouth & Poole Early Implementer – Health & Wellbeing Board**

1. PURPOSE

1.1 To provide Scrutiny Coordinating Committee with detail on the findings of consultation with Bournemouth and Poole Shadow Health and Wellbeing Board. The consultation was undertaken to support the development of a scrutiny function, at Hartlepool, that will fulfill our statutory role of Scrutiny in respect of the implementation of the Hartlepool Health & Wellbeing Board.

2. BACKGROUND

2.1 Bournemouth & Poole's Shadow Health & Wellbeing Board is deemed as an 'Early Implementer' for this Executive function by the Department of Health. They are two separate Local Authorities, maintaining their sovereignty, whilst recognising the value of collaboration in respect of Health & Wellbeing and a review of their Joint Strategic Needs Assessment (JSNA). They are governed by a Leader & Cabinet model and have one NHS Hospital Trust covering their Local Authority areas similar to Hartlepool's arrangement with Stockton (North Tees).

3. CONSULTATION

3.1 It was evident from our consultation that collaboration between the Primary Care Trust and the two boroughs at a high strategic level afforded them the opportunity to map the collective issues and emerging priorities.

3.2 The local consultation was undertaken collaboratively with a view to refresh the JSNA and subsequently set out the key issues covering how the population is changing, what the current Health & Wellbeing status is, detail the significant health inequalities, and consider the wider determinants of health such as income, housing, education and environment can contribute to differences in Health & Wellbeing locally.

3.3 The consultation confirmed the importance of refreshing the JSNA as it will underpin the Health & Wellbeing Strategy. Through this exercise you will be able to identify emerging priorities that must be captured in the Health & Wellbeing Strategy by key officers. It is imperative that this exercise is facilitated centrally but contributed to by all key stakeholders, including elected members, to ensure the Health & Wellbeing Strategy incorporates the most significant needs and issues arising from the JSNA process. The importance of this process can not be underestimated as the JSNA should support the development of clinical commissioning intentions both by the Health & Wellbeing Board but also the emerging Clinical Commissioning Group.

3.4 The production of the JSNA is a statutory duty for upper tier authorities and health partners as set out in the Health & Social Care Act 2012. Any refreshed JSNA and associated documentation should also include key Health & Wellbeing information for the protected characteristics identified in the Equality Act 2010. It should also have due regard to poverty and disadvantage, that may have disproportionate impacts on some groups in the population with protected characteristics. This information should therefore be considered by commissioners when identifying how needs contained within the JSNA can be better met by public services.

4. CONSULTATION QUESTIONS

4.1 We asked Bournemouth and Poole some key questions:

How do you consider the Overview and Scrutiny function working?

Answer – At the present time they consider Overview and Scrutiny as two separate work streams. Overview is their current work activity as this is prior to implementation of the Health & Wellbeing Strategy whilst Scrutiny will be post implementation.

What is the composition of your Health & Wellbeing Board?

Answer - There is a joint Chair shared between the two Local Authority areas, the Joint Director of Public Health covering the two areas, 3 Assistant Directors covering the two areas plus a neighbouring authority, Vice Chair from the Clinical Commissioning

Group (CCG), 2 members from the Local Involvement Networks (LINks), 3 Councillors from each (Executive and Non Executive), 2 Directors, 2 G.P.'s, 2 members from the Voluntary & Community Sector (VCS) i.e. the relevant manager from umbrella organisations and also the Joint Director for Commissioning & Development.

In what format do you produce your JSNA?

Answer - The JSNA is web based and living document permanently open to consultation. The strategy behind it is under development and is already a persuasive document in readiness for going live with the Health & Wellbeing Board.

What were you key priorities

Answer:

Reducing Inequalities

- Helping Children and Young people reach their potential
- Working with complex families
- Tackling poverty and worklessness
- Developing more affordable housing
- Tackling domestic abuse
- Tackling crime and anti-social behaviour
- Prioritise deprived communities

Promoting Healthy Life-Styles and preventing ill-health

- Promoting Physical activity
- Preventing alcohol harm
- Promoting good sexual health
- Promoting positive mental health

Working better together to deliver high quality care and better value

- Improving services for children and young people with emotional and mental health problems
- Improving adult mental health services
- Improving services for people with long term conditions/chronic disease
- Improving services for people with dementia
- Safeguarding children and adults from abuse and harm
- Supporting carers including young carers

- Improving services for children with disabilities and complex needs

How have you developed a working relationship with the Clinical Commissioning Group?

Answer – Through joint briefing meetings. Joint training, which has been facilitated by the Local Government Association (LGA).

5. SUMMARY

5.1 The consultation with Bournemouth & Poole provided the following information:

- There is one Health & Wellbeing Strategy covering the Hospital Trust and CCG area: they seek opportunities to share resources whilst recognising the varying needs and assets between and within the boroughs and CCG localities
- The strategy builds on the skills and contributions of local communities with the view of tackling problems together
- The strategy should provide a framework for continuous discussions that involves local people in its development
- They have a three year strategy with the aim of annual refresh to reflect what may be a fast changing environment
- The strategy should reflect the needs and inequalities identified in the JSNA
- It should focus on key priority areas (as above)
- It must be clear and concise, detailing how improvements are going to be delivered
- In the current economic climate you may be able to achieve better value and more qualitative outcomes by working together
- Any strategy should also set out clear accountability and monitoring arrangements, which actively identifies where we need to improve the way key partners work together

HEALTH SCRUTINY FORUM

7 February 2013

Report of: Scrutiny Support Officer

Subject: SIX MONTHLY MONITORING OF AGREED HEALTH SCRUTINY FORUM'S RECOMMENDATIONS

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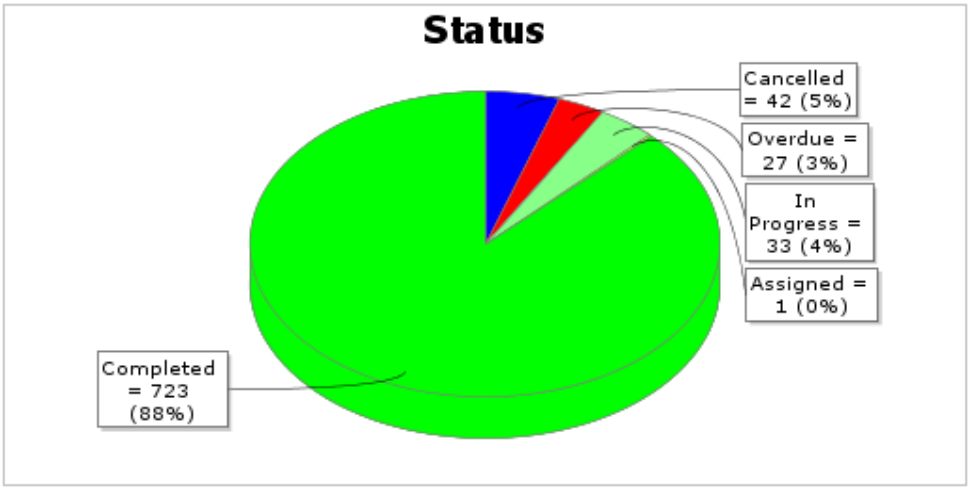
1. PURPOSE OF REPORT

1.1 To provide Members with the six monthly progress made on the delivery of the agreed scrutiny recommendations of this Forum.

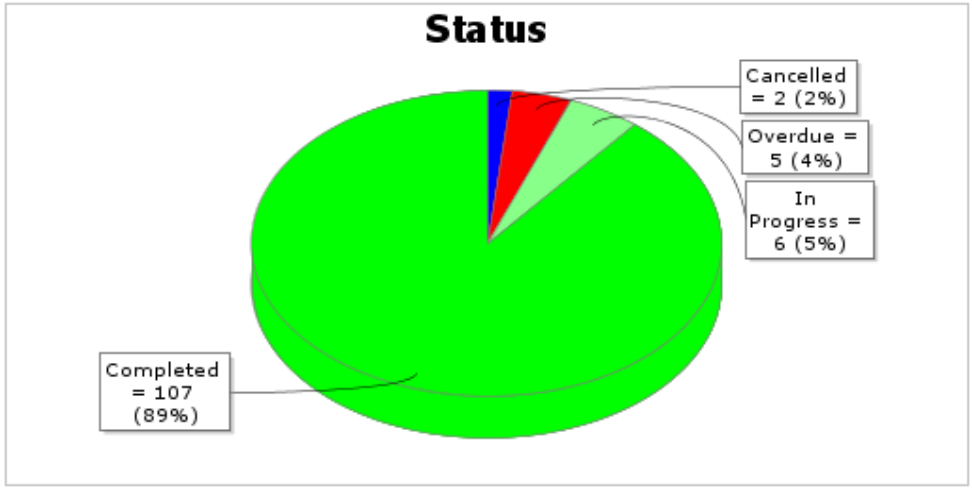
2. BACKGROUND INFORMATION

2.1 In accordance with the agreed procedure, this report provides for Members details of progress made against each of the investigations undertaken by the Forum. **Chart1** below is the overall progress made by all scrutiny forums since 2005 and **Chart2** (overleaf) provides a detailed explanation of progress made against each scrutiny recommendation agreed by this Forum since the last six monthly monitoring report presented in September 2012.

Chart1: Progress made by all Scrutiny Investigations Undertaken since 2005



Year 2008/09
Investigation Reaching Families in Need



Health Scrutiny Forum - All

Generated on: 25 January 2013

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/1a That the local authority take the lead in providing a co-ordinated leadership approach across the different providers in	SCR-HSF/1a/i	The government has provided guidance regarding a "Think Family" initiative that we are developing in Hartlepool. This initiative will support this recommendation and will	~~Ann Breward~~; John Robinson	01-Mar-2011	01-Mar-2013	11-Jan-2013 The Peer review was very supportive of the Early Intervention Strategy and in particular commented positively on the Information Hub and the Localities. The peer review identified	88% In Progress	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
order to facilitate a systematic approach to tackling health inequalities in the town.		endeavour to lead a culture change in the way that our services are designed.				issues around the lack of identity of the Children's Centres within communities and a strategy is being developed to take on this challenge. The implementation of the early years pathway is moving forward with the locality hotspots being identified and the full programme being agreed with colleagues in health. It has been agreed that teenage mothers will become a locality hotspot and consequently every teenage parent will have an enhanced service. Full launch date will be April 2013.		
						03-Oct-2012 The Early Intervention Strategy has been operational since June 11th 2012 and is being monitored by the implementation group. Early indicators are that partners are getting used to the new systems and are happy with services. Figures for the first full quarter will be available soon. The service was involved in a peer review and we are waiting for the final report.		

Year 2009/10
Investigation Alcohol Abuse - Prevention and Treatment

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/3h In promoting safe, sensible drinking, that the Council be encouraged to evaluate any opportunities to work towards recognising the Town	SCR-HSF/3h	Securing Purple Flag status would be challenging and is an aspiration at this time considering the current level and baseline. Improvements would include not only the participation of licensees but also consideration of the	Ian Harrison	30-Sep-2011	30-Sep-2012	24-Jan-2013 The Council is continuing to make incremental improvements to the Night time Economy and the introduction of an EMRO in August 2013 will play a significant positive role. Achieving Purple Flag status is however dependent upon the agreement and	70% Overdue	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
Centre as a Purple Flag zone.		wider night time economy environment which does need significant investment. There is however a tiered development plan in place to work towards this award. This includes more positive engagement with the trade to develop higher standards of customer care; more consideration of safe routes home and closer working with town centre management. One of the first stages is the voluntary adoption of voluntary codes by operators and moving to the introduction of the Best Bar None scheme. There will also be a review of the impact of the Transport Interchange.				cooperation of licensees and other businesses and therefore, whilst partnership working remains strong, it is not possible to state that Purple Flag will be achieved by any particular date. 18-Jan-2013 The Council's Licensing Committee has determined that the Council should look towards introducing an Early Morning Alcohol Restriction Order and public consultation will be commencing shortly. The date for the introduction of the EMRO has been scheduled as 13th August 2013. It is hoped that this will have a significant positive impact on the night time economy.		

Year 2010/11
Investigation Connected Care

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/5b/iv That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (iv) That a feasibility study is carried out into support for the Connected Care roll-out through the transfer of staff.	SCR-HSF/5b/iv	Monitoring the development of the model across Hartlepool will determine whether the outcomes justify the transfer of resources in the future.	Jill Harrison; Geraldine Martin	31-Mar-2013	31-Mar-2013	17-Jan-2013 The connected care model is currently funded from a range of sources until March 2013 at a total cost of £340k p.a - this includes care navigation, the Supported Access to Independent Living (SAIL) service and the Handyperson Service. Funding sources include PCT Funding for Social Care (£120k), PCT Reablement Funding (£120k), PCT base budget (£50k) and HBC base budget (£50k). The longer term	95% In Progress	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						viability of commissioning the model across Hartlepool will be determined by the outcomes achieved between November 2011 and March 2013 and the continuation of funding beyond that date, which is unconfirmed at this time. A six month contract review has been completed and indicated that the service was delivering good outcomes. An annual review is currently underway and due to be completed by end of January 2013.		
						08-Jan-2013 Annual review in progress and to be completed by the end of January 2013. Consideration being given to extend the contract for 12 months.		
SCR-HSF/5c/i That following the completion of the work being undertaken by the LSE:- (i) That the findings are shared with the Health Scrutiny Forum.	SCR-HSF/5c/i	Research findings from LSE will be presented to Health Scrutiny Forum.	Geraldine Martin	31-Aug-2012	31-Aug-2012	24-Jan-2013 -- enter new status update --Who Cares NE have handed all the data to Jane Wistow who has been commissioned by the LSE to evaluate the findings. Sickness has delayed the process but the evaluation will be shared as soon as it is available.		
						17-Jan-2013 The London School of Economics (LSE) is doing a piece of work to evaluate the cost/benefits associated with Who Cares (NE) services with a particular focus on a) how we can demonstrate that low level interventions save money further down stream and b) being able to quantify the cost saving against a particular intervention. The data is currently being evaluated but the research findings are not yet available.	80% Overdue	
SCR-HSF/5c/ii That following the	SCR-HSF/5c/i	Positive outcomes highlighted in the LSC research will be	Geraldine Martin	30-Sep-2012	30-Sep-2012	24-Jan-2013 All the data has been collected and Who Cares NE have	80% Overdue	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
completion of the work being undertaken by the LSE:- (ii) That where evidence demonstrates the financial benefits of Connected Care, those organisations benefitting from early intervention by Connected Care.	i	used to encourage all agencies that benefit from the preventative / early intervention approach to contribute to the ongoing delivery of services via a connected care model.				handed it to Jane Wistow who has been commissioned by the LSE to evaluate the findings. Sickness has delayed the research evaluation being completed but the findings will be made available as soon as possible. 17-Jan-2013 The London School of Economics (LSE) is doing a piece of work to evaluate the cost/benefits associated with Who Cares (NE) services with a particular focus on a) how we can demonstrate that low level interventions save money further down stream and b) being able to quantify the cost saving against a particular intervention. The data is currently being evaluated but the research findings are not yet available.		

Year 2011/12
Investigation Cancer Awareness and Early Diagnosis

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/6a/i That in relation to the Teesside Cancer Awareness Roadshow (i) Hartlepool Borough Council hosts a Roadshow ensuring messages are embed in the Council's health and wellbeing promotion to staff.	SCR-HSF/6a/i	Plans are well in hand to deliver cancer roadshows for council staff. The dates of these events are as follows: 16th August - Civic Centre, 12th September - Civic Centre, 13th September - Brian Hanson, 24th September - Brian Hanson, 18th October - Civic Centre. There are also other events open to a wider audience in venues such as Middleton Grange car park planned.	Steven Carter	30-Nov-2012	30-Nov-2012		0% Overdue	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		Voluntary and community groups in the town are also accessing small pots of money to facilitate delivery of cancer roadshows to reach wider community audiences.						
SCR-HSF/6a/ii That in relation to the Teesside Cancer Awareness Roadshow (ii) Hartlepool Borough Council encourages appropriate Town based community venues and events to host a Teesside Cancer Awareness Roadshow	SCR-HSF/6a/ii	Plans are well in hand to deliver cancer roadshows for council staff. The dates of these events are as follows: 16th August - Civic Centre, 12th September - Civic Centre, 13th September - Brian Hanson, 24th September - Brian Hanson, 18 October - Civic Centre. There are also other events open to a wider audience in venues such as Middleton Grange car park planned. Voluntary and community groups in the town are also accessing small pots of money to facilitate delivery of cancer roadshows to reach wider community audiences.	Steven Carter	30-Nov-2012	30-Nov-2012		0% Overdue	
SCR-HSF/6e That the evidence about the impact of the role of the former Head of Community Midwifery in encouraging access to stop smoking services by pregnant women, be emphasised with North Tees and Hartlepool NHS Foundation Trust	SCR-HSF/6e	Continue to implement the smoking in pregnancy action plan as part of the wider smoking cessation programme. Support from North Tees and Hartlepool NHS Foundation Trust has continued despite staffing changes. Improvement in reducing smoking in pregnancy continues in Hartlepool.	Carole Johnson	30-Apr-2013	30-Apr-2013	02-Jan-2013 The North of Tees Smoking in Pregnancy Group continues to meet regularly to oversee the implementation of the action plan for 12/13. A regional project is being developed to work with all Acute Trusts in the North East to deliver a more 'hard hitting' approach to those pregnant smokers who decline stop smoking support. Tees is due for roll out of the programme in May/June 2013. Successful delivery will be very dependent on Acute Trust commitment.	75% In Progress	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
						24-Oct-2012 the North of Tees Smoking in Pregnancy Steering Group continues to meet regularly to oversee the implementation of the action plan for 12/13. Work is progressing well.		
SCR-HSF/6f That Hartlepool Borough Council, through its new Public Health responsibility, ensures that young people in schools and youth groups receive appropriate hard hitting messages about the cancer risk of smoking, alcohol and poor diet.	SCR-HSF/6f	The British Heart Foundation funded project commenced on 1st April. This is a 3 year project aimed at children and young people between 7-14 years and will focus on the issues of smoking, healthy eating and increasing physical activity. Although aimed at preventing heart disease there will be an impact on cancer prevention.	Chris Briddon	30-Apr-2013	30-Apr-2013	23-Aug-2012 Preliminary work has been ongoing with the schools to engage them into the project. Workshops are being developed . Launch 4th October 2012 Workshops with children 7-14 yrs across all schools in Hartlepool will have workshops on heart health/ healthy eating/ anti -smoking / importance of physical activity , it is hoped this will have an impact on the reduction of childhood obesity across Hartlepool with a decline in the incidence of CVD in adulthood. The CVD Primary prevention messages given to the children will also emphasise the effect these behaviour changes/ lifestyle will have on the reduction in cancer. A number of Jibber workshops (plays with a anti-smoking message) have been delivered across all the secondary schools.	14% In Progress	
SCR-HSF/6g/i That in line with the smoke free workplace, HBC develops a strategy with partner organisations that Educates licensed taxi drivers about the effects of passive smoking, reminding them of the legislation of not smoking in the	SCR-HSF/6g/i	HBC's Public Protection Team carry out programmed inspections of all premises, including licensed vehicles such as taxis. These inspections include confirmation of compliance with the requirement to display 'No Smoking' signs in the vehicles. Failure to display the	Ian Harrison	30-Apr-2013	30-Apr-2013	18-Jan-2013 The Trading Standards Service has, on a temporary basis, a tobacco control officer who monitors legal compliance on all tobacco issues, including smoking in smoke free areas, the underage sale of tobacco products and the sale and supply of illicit tobacco. This officer has contributed towards the current information that is passed to taxi drivers prior to their knowledge tests and will be working	33% In Progress	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
workplace		appropriate signage or to smoke, or allow smoking, in a licensed vehicle is a criminal offence. Drivers and vehicle owners who breach this requirement face prosecution. Drivers are tested on their knowledge and understanding of tobacco control law as part of their 'knowledge test' prior to obtaining their first licence. To date, no one has been prosecuted in Hartlepool for a continued breach of these requirements but a number of warnings have been issued.				with partner agencies to shortly develop a plan to deal with existing drivers.		
SCR-HSF/6g/ii That in line with the smoke free workplace, HBC develops a strategy with partner organisations that determines appropriate enforcement options for licensed taxi drivers who are in breach of the smoke free workplace	SCR-HSF/6g/ii	HBC's Public Protection Team carry out programmed inspections of all premises, including licensed vehicles such as taxis. These inspections include confirmation of compliance with the requirement to display 'No Smoking' signs in the vehicles. Failure to display the appropriate signage or to smoke, or allow smoking, in a licensed vehicle is a criminal offence. Drivers and vehicle owners who breach this requirement face prosecution. Drivers are tested on their knowledge and understanding of tobacco control law as part of their 'knowledge test' prior to obtaining their first licence.	Ian Harrison	30-Apr-2013	30-Apr-2013	18-Jan-2013 Enforcement options available to the Council are detailed in legislation and generally involves either prosecution, fixed penalty notice or an informal warning. To date, no prosecutions have taken place and enforcement officers do not have the delegated power to issue fixed penalty notices. A number of warning have been issued - including to taxi drivers and taxi operators. The ability for Public Protection Officers to issue fixed penalty notices is being investigated by a number of North East Councils and the matter will be considered further if it is established that delegations are possible.	40% In Progress	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		To date, no one has been prosecuted in Hartlepool for a continued breach of these requirements but a number of warnings have been issued.						

Year 2008/09
Investigation Reaching Families in Need

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/1b That subject to the implementation of recommendation 1a, the local authority, acting as strategic leader, enter into formal arrangements with partner organisations (i.e. Police, PCT, FT, Housing Hartlepool and the Voluntary Sector).	SCR-HSF/1b	The Think Family Reforms will be reported through the Children's Trust that includes all major stakeholders in this process.	~~Ann Breward~~; John Robinson	01-Mar-2011	01-Mar-2013	03-Oct-2012 Reporting Mechanisms are now in place. 13-Jul-2012 On June 11th the Information Hub and the Locality Teams became active. It has been agreed that the service will report to the safeguarding board, Children Portfolio and the Wellbeing board at regular intervals.	100% Completed	
SCR-HSF/1c That the FIP Project be expanded in light of its effectiveness thus far in targeting hard to reach families.	SCR-HSF/1c	The Family Intervention Project (FIP) is currently being developed as an integrated part of the Team around the School initiative. This service has been designed to enable new services to be bolted onto it and to adopt the FIP approach to assertive support.	~~Ann Breward~~; John Robinson	01-Dec-2011	01-Dec-2011	10-Jan-2012 FIP is now an integral part of services. 08-Jul-2011 The FIP continues to get national focus and in Hartlepool we continue to develop the FIP to complement other work programmes.	100% Completed	
SCR-HSF/1g That in order to strengthen links and	SCR-HSF/1g	We will explore current communication routes being developed by community	~~Ann Breward~~; John Robinson	01-Mar-2011	01-Dec-2011	10-Jan-2012 Ecaf will be implemented after testing in January and all key partners have	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
communication routes between agencies, the establishment of a co-ordinated, single point of contact for the referral of information and referrals from any source be explored.		safety, the Team Around the School Initiative and Family Information Service to further this action and provide a report to the Children's Trust and Cabinet.				agreed to participate. The Early Intervention Strategy includes plans to develop an information Hub that will include the learning from the successful implementation of the CAF service. 08-Jul-2011 The Common Assessment Team will start a pilot in August and will model new practice linked to the early intervention service and the Duty Team.		
SCR-HSF/1h That the feasibility of introducing a similar way of gathering and sharing data in Hartlepool, as has been implemented by Westminster Council (i.e. a Multi-Agency Information Desk) be explored.	SCR-HSF/1h	We will investigate this issue as part of the development of the Common Assessment Framework linked in with the Children's Trust, the Local Safeguarding Children Board and the Safer Hartlepool Partnership. These developments will need to take account of the current sub regional agreements that are in place.	~~Ann Breward~~; John Robinson	01-Mar-2011	01-Dec-2011	10-Jan-2012 Ecaf will be implemented after testing in January and all key partners have agreed to participate. The Early Intervention Strategy includes plans to develop an information Hub that will include the learning from the successful implementation of the CAF service. 08-Jul-2011 The Common Assessment Team will start a pilot in August and will model new practice linked to the early intervention service and the Duty Team.	100% Completed	

Year 2009/10
Investigation Alcohol Abuse - Prevention and Treatment

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/3c/ii Looks to pool resources in the treatment and prevention of alcohol related problems	SCR-HSF/3c/ii	The terms of reference for the Strategy Group and the self assessment/improvement plan confirm a commitment to pool and maximise resources for more effective	Michelle Chester; Chris Hart	30-Apr-2011	30-Apr-2012	01-Feb-2012 Alcohol, drug and offending budgets integrated and managed through joint substance misuse Commissioning Group 13-Oct-2011 Review of Safer	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		responses. This will be influenced however by the Governments announcement on funding allocations and governance structures e.g. GP Commissioning and the abolition of Primary Care Trusts, the detail of which is not likely to be known until January 2011.				Hartlepool Partnership structures confirmed terms of reference and activity of Substance Misuse Commissioning Group and Alcohol Strategy Group. Investment for drug services increased for 2011/12 with general advice that llocation will continue at similar levels for 2012/13.Resources for alcohol limited and Total Place exercise planned for Q3/4. In addition discussion initiated with GP Consortia in advance of proposed NHS changes to structures, finance and commissioning responsibilities.		
SCR-HSF/3e/i The funding of alcohol treatment and prevention services is ring-fenced and mirrors illegal drug treatment and prevention	SCR-HSF/3e/i	NHS Hartlepool Board considered the recommendations of the investigation at the board meeting in July. It was acknowledged by the PCT Board that alcohol and the funding of treatment services is a key priority. Officers will continue to work to identify resources on a recurring basis through the QIPP programme, particularly as it is recognised that there is a significant pressure on hospital services from alcohol related harm.	Louise Wallace	31-Mar-2011	31-Mar-2012	09-Jan-2012 Action complete 12-Oct-2011 The NHS Hartlepool funded QIPP scheme is now being delivered to reduce emergency admissions. This is in keeping with the Alcohol Strategy overseen by the Alcohol Strategy Group.	100% Completed	
SCR-HSF/3e/ii The current delivery model is made sustainable and the ability to increase the capacity of providers, whilst maintaining the current high standard, is prioritised.	SCR-HSF/3e/ii	NHS Hartlepool Board considered the recommendations of the investigation at the board meeting in July. It was acknowledged by the PCT Board that alcohol and the funding of treatment services is a key priority. Officers will continue to work to identify	Deborah Gibbin; Carole Johnson; Louise Wallace	31-Mar-2011	31-Mar-2012	24-Apr-2012 The tendering of drug and alcohol services jointly funded between the Pooled Treatment Budget and mainstream NHS resources is now complete. 08-Mar-2011 NHS Hartlepool Board agreed in January 2011 that alcohol treatment and prevention services should be a priority. Currently in the	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		resources on a recurring basis through the QIPP programme, particularly as it is recognised that there is a significant pressure on hospital services from alcohol related harm.				process of identifying a supporting budget to secure funding for 2011/12 resource.		
SCR-HSF/3f/i Address the problem of why people exhibiting risky behaviour in terms of alcohol don't utilise their GP as their first point of contact	SCR-HSF/3f/i	Work is ongoing to develop the GP Locally Enhanced Service (LES) to ensure GPs are able to offer effective and appropriate services for people in primary care. The LES has been drafted and is now in the process of being consulted on.	Deborah Gibbin; Carole Johnson; Louise Wallace	31-Mar-2011	31-Mar-2012	24-Apr-2012 This work will be taken forward through Clinical Commissioning Group (NHS) in the light of the new alcohol strategy. 09-Jan-2012 Discussions are ongoing with the Clinical Commissioning Group regarding alcohol treatment pathways and investment in services.	100% Completed	
SCR-HSF/3f/ii Ensure that all GP practices are trained in terms of brief interventions	SCR-HSF/3f/ii	Any training issues are expected to be identified through this process. This LES will ensure that GPs are a first point of contact as they will be actively engaging with patients who have hazardous and harmful drinking behaviours.	Deborah Gibbin; Carole Johnson; Louise Wallace	31-Mar-2011	31-Mar-2012	09-Jan-2012 Action complete 12-Oct-2011 Brief interventions training is ongoing as part of the QIPP programme across primary and social care.	100% Completed	

Year 2010/11
Investigation Connected Care

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/5a That a strategy is devised to identify those communities within Hartlepool who may benefit from the delivery of the Connected Care model.	SCR-HSF/5a/i	The external evaluation for the delivery and impact of connected care has been very positive. Ongoing funding is in place via both the Council and the PCT for the development of care navigation services (which	Jill Harrison; Geraldine Martin	31-Mar-2013	31-Mar-2013	03-Jan-2012 Who Cares (NE) has now received the additional 2 years funding to enable the SAILS and handyperson services to be developed across the town. Who Cares is working closely with local partners from the North and Central areas of town to ensure a localised	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		were originally planned for the Owton Ward). It is proposed to use this funding for a further two years to enable services to be developed in other communities using the connected care model of community audits and bringing together existing community groups to deliver seamless services.				response in the way the services are shaped in each area.		
SCR-HSF/5a That a strategy is devised to identify those communities within Hartlepool who may benefit from the delivery of the Connected Care model.	SCR-HSF/5a/ii	As part of the reablement plan delivery the PCT and LA have agreed that a range of low level health and social care services can be provided as part of the connected care model of service delivery. It was therefore agreed to commission services across the town that provide low level support and prevention to maintain people within their own communities (including welfare notices, luncheon clubs, handy person service, fuel poverty advice and a home visiting service) for two years from April 2011. It is envisaged that this in the first instance this may involve all local organisations in coordinating these type of services in the medium term.	Jill Harrison; Phil Hornsby	31-Jul-2013	31-Jul-2013	04-Jan-2012 The Supported Access to Independent Living (SAIL) service has been commissioned from 1 November 2011 to provide a range of low level services across Hartlepool in line with the connected care / care navigation model. Services include the handyperson service, home visiting, welfare notices, luncheon clubs and social activities. Who Cares (NE) is the overarching organisation holding the contract and is working with other local organisations to co-ordinate services and avoid duplication. The Board of Who Cares (NE) now includes representatives from the North and Central areas of the town (elected members, voluntary sector group representatives and residents) to ensure that a local focus is maintained.	100% Completed	
SCR-HSF/5b That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool	SCR-HSF/5b	Discussions to be undertaken with local areas to ascertain if developing the connected care model in their areas would be a positive development. If this is the case then agreement on how	Jill Harrison; Geraldine Martin	31-Mar-2013	31-Mar-2013	26-Mar-2012 The contract awarded to Who Cares (NE) from 1 November 2011 has facilitated the development of the connected care approach in other areas. A range of services are provided across the town including Handyperson	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
		this will be facilitated in each area and who will be involved is required. This may be different in different areas of the town as per the model of connected care development. It is hoped that the CIC Who Cares (NE) may facilitate this dialogue with residents and community groups in the different areas.				Service, luncheon clubs and Supported Access to Independent Living Services (SAILS). Who Cares (NE) are involved in discussions and dialogue with a wide range of organisations across the town to determine how services will be delivered to meet local needs. 04-Jan-2012 The development of the Who Cares (NE) Board to include representatives from the North and Central areas (elected members, residents and voluntary sector representatives) will ensure that there is an ongoing dialogue with local communities.		
SCR-HSF/5b/i That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (i) Ensuring that the necessary governance structure is in place.	SCR-HSF/5b/i	In each area a robust governance structure will be developed that has a local project group to steer and drive the developments and to ensure a truly local focus is developed. Also representatives from the central and north area projects will be part of the development of a town wide Who Cares (NE) Partnership Group to ensure the CIC develops as a true town wide entity.	Geraldine Martin	30-Sep-2011	31-Mar-2013	17-Jan-2013 The Who Cares (NE) Board continues to have membership from the North, South and Central areas to ensure that services have a local focus and that appropriate governance arrangements are maintained. Navigation services, the handyperson service and Supported Access to Independent Living Services (SAILS) are now in place across the town and received over 2,300 referrals between November 2011 and October 2012. An annual review of the contract is currently underway, and will be completed by the end of January 2013. 08-Jan-2013 Annual review is progress and will be completed by the end of January 2013. Contract ends March 2013 and consideration being given to extend for 12 months.	100% Completed	
SCR-HSF/5b/ii That once recommendation	SCR-HSF/5b/i	Each local area will develop and complete its own audit to	Geraldine Martin	30-Sep-2012	30-Sep-2012	02-Oct-2012 -- enter new status update --As previous update.	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
(a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (ii) Identifying the needs of the individual community from residents and ensuring the delivery of a bespoke service.	i	identify how a connected care approach will inform the development of models that meet local needs. Who Cares (NE) can facilitate audits in other areas if required. At the request of local people in Burbank, Who Cares (NE) has already begun to work with local residents and organisations to complete a community audit in Burbank.				04-Jul-2012 Surveys completed across the town and Who Cares NE works closely with local providers and residents in each of the 3 areas to ensure a local focus for service developments.		
SCR-HSF/5b/iii That once recommendation (a) is completed, Connected Care is rolled-out to other communities in Hartlepool:- (iii) Ensuring that partnership arrangements are in place for current service providers.	SCR-HSF/5b/iii	The success of the connected care model is based on bringing together existing services and community organisations within local communities to reduce duplication and encourage partnership approaches. Who Cares (NE) can facilitate this development in other areas to ensure that there is local ownership and that despoke services are developed, tailored to local needs. It would be a requirement within any contract linked to connected care that this approach to partnership is followed.	Geraldine Martin	31-Mar-2013	31-Mar-2013	17-Jan-2013 The Who Cares NE Board brings together representation from across the town and members are working closely together to ensure that services are developed to reflect a local focus and that bids are placed for additional funding wherever possible as a joint venture. 04-Jul-2012 -- enter new status update --	100% Completed	
SCR-HSF/5d That in order to ensure the safety of Connected Care Navigators and as part of a multi-disciplinary approach to meeting the needs of individuals, that a feasibility study be undertaken into Navigators accessing	SCR-HSF/5d	Work has already commenced to explore how staff delivery prevention and early intervention services can have access to the Care First system and the Employee Protection Register (EPR).	Trevor Smith	31-Dec-2012	31-Dec-2012	17-Jan-2013 Discussions took place in July-August 2012 between the Council's Violence Against Staff (VAS) group (that oversees the Employee Protection Register (EPR) system) and managers of Who Cares NE to decide how access can be given to the EPR system for connected Care Navigators. An Information Sharing Protocol (ISP) was then created that	100% Completed	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress	
Care First, Rio, EPR.					determined the way in which SAIL staff could use the system - this was signed by both HBC and SAIL managers, and agreed at the council's VAS group. Following this, accounts have been created for 5 SAIL staff to access the EPR system, as well as a HBC email account (SAIL@hartlepool.gov.uk) set up for communications between SAIL staff and relevant council workers on a secure basis. SAIL Navigators are now invited & attend the EPR regular monthly meetings with council staff to address EPR related issues from both a worker and client perspective.		

Year 2011/12
Investigation Cancer Awareness and Early Diagnosis

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
SCR-HSF/6b That Hartlepool's Health and Wellbeing Board ensures that Stop Smoking Services and smoking cessation is embedded in the JSNA.	SCR-HSF/6b	The 2012/13 JSNA on smoking has been completed and is 'live' on the website. www.teesjsna.org.uk	Carole Johnson	31-Jul-2012	31-Jul-2012	09-Oct-2012 The Smoking and tobacco control section of the JSNA is complete and live	100% Completed	
SCR-HSF/6c/i That in relation to whether there is a link between high risk industrial workers and contraction of cancers through the ingestion of particulates,such as	SCR-HSF/6c/i	A literature review will be undertaken on this issue and the result fed back to Health Scrutiny Forum. This action was agreed by the Hartlepool and North Tees Clinical Commissioning Board in December 2012.	Deborah Gibbin; Carole Johnson; Louise Wallace	30-Nov-2012	30-Nov-2012	07-Jan-2013 This literature review is now underway and will be completed by the end of January.	100% Completed	

Recommendation	Action		Assigned To	Original Due Date	Due Date	Note	Progress	
coal dust (i) the Public Health Directorate carries out a literature research								
SCR-HSF/6c/ii That in relation to whether there is a link between high risk industrial workers and the contraction of cancers through the ingestion of particulates, such as coal dust (ii) this information is shared with the HSF.	SCR-HSF/6c/ii	A literature review will be undertaken on this issue and the result fed back to the Health Scrutiny Forum. This action was agreed by the Hartlepool and North Tees Clinical Commissioning Board in December 2012.	Deborah Gibbin; Carole Johnson; Louise Wallace	30-Nov-2012	30-Nov-2012	08-Jan-2013 Literature review will be completed by end of January	100% Completed	
SCR-HSF/6d/i That NHS Hartlepool and the emerging CCG (i) ensure that cancer screening levels are improved across GP Practices in Hartlepool; and	SCR-HSF/6d/i	The Director of Public Health will ensure that the Hartlepool Clinical Commissioning Group is informed about levels of uptake across the various screening programmes and ensure actions are taken to promote uptake across all eligible populations. This action was agreed by the Hartlepool and North Tees Clinical Commissioning Board.	Deborah Gibbin; Carole Johnson; Louise Wallace	30-Nov-2012	30-Nov-2012	23-Oct-2012 This was done during first week of October.	100% Completed	
SCR-HSF/6d/ii That NHS Hartlepool and the emerging CCG (ii)Devise and share a strategy with the Health Scrutiny Forum for targeting cancer screening and awareness activity in the workplace / venues where residents gather socially;	SCR-HSF/6d/ii	The Director of Public Health will write a strategy for increasing awareness of the importance of screening programmes. This strategy will focus on maximising opportunities within the local community and amongst employers. A key part of the strategy will be to engage occupational health departments. This action was agreed by the Hartlepool and	Deborah Gibbin; Carole Johnson; Louise Wallace	30-Nov-2012	30-Nov-2012	23-Oct-2012 Action competed but will need reviewing in 2013 in the light of the creation of Public Health England.	100% Completed	

Recommendation	Action	Assigned To	Original Due Date	Due Date	Note	Progress	
	North Tees Clinical Commissioning Board.						

3. REQUESTED REVISIONS TO ACTION DUE DATES

3.1 The Forum is requested agree to a revision of the completion dates for the actions detailed in **Table 1** for the reasons outlined.

Table 1 Requested Due Date Revisions

Recommendation	Action	Original Due Date	New Due Date	Note
SCR-HSF/3h	Securing Purple Flag status would be challenging and is an aspiration at this time considering the current level and baseline. The Council is continuing to make incremental improvements to the Night time Economy and the introduction of an EMRO in August 2013 will play a significant positive role. Achieving Purple Flag status is however dependent upon the agreement and cooperation of licensees and other businesses and therefore, whilst partnership working remains strong, it is not possible to state that Purple Flag will be achieved by any particular date.	30-Sep-2012	30-Sep-2013	New Due date to allow for the introduction of an Early Morning Alcohol Restriction Orders (EMRO)

4. RECOMMENDATIONS

4.1 That Members:-

(a) Note progress against the Health Scrutiny Forum's agreed recommendations, since the 2005/06 Municipal Year, and explore further where appropriate; and

(b) Agree the proposed date changes to the action(s) included in paragraph 3.1

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523087
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BACKGROUND PAPERS

No background papers were used in the preparation of this report.

HEALTH SCRUTINY FORUM

7 February 2013

Report of: Scrutiny Support Officer

Subject: NORTH EAST AMBULANCE SERVICE – QUALITY ACCOUNT 2013/14 – COVERING REPORT

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1. PURPOSE OF REPORT

1.1 The North East Ambulance Service (NEAS) are in the process of developing their Quality Account 2013/14 and have requested feedback from the Health Scrutiny Forum.

2. BACKGROUND INFORMATION

2.1 Health Scrutiny Forum's are ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents. The priorities should reflect the three domains of quality set out in High Quality Care for All: patient safety, clinical effectiveness and patient experience.

2.2 In addition to the locally set priorities there are 5 mandatory indicators that will be published alongside:

- Category A Incidents within 8 minutes
- Category A incidents within 19 minutes
- STEMI Care Bundle
- Stroke Care Bundle
- Staff views on standards of care – the response to the NHS staff survey questions "if a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust"

2.3 Due to tight timescales, NEAS have asked that the Health Scrutiny Forum ranks the attached priorities in Appendix A in the order that they feel is most important and provides relevant commentary to NEAS by 22 February 2013.

3. RECOMMENDATIONS

3.1 That Members note the content of this report, rank the attached priorities in Appendix A in the order that they feel is most important and provides relevant commentary to NEAS by 22 February 2013.

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
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BACKGROUND PAPERS

No background papers were used in the preparation of this report.

Area	Possible Quality Account Objectives	Further Detail
PTS	To introduce appointment based service through the first Quarter of 2013/14 across entire NEAS service. Move away from banding times for PTS and towards transporting patients to their appointment time (+/- 15mins)	Particular focus on introduction of an appointment based service through the first Quarter of 2013/14 across entire NEAS service. Move away from banding times for PTS and towards transporting patients to their appointment time (+/- 15mins)
PTS	To achieve year on year improvements in patient satisfaction, through the development of a patient charter and continued survey work.	Ensure that people have a positive experience of care, and achieve a year on year reduction in patients complaints.
CC/QP	Develop high performing, patient and performance focused integrated call taking functions.	Utilise synergy working practices and cross training to develop multiskilled call takers providing a flexible workforce. The growth and development of staff will allow better patient experience.
CC/QP	Develop a high performing, patient and performance focused integrated dispatch/planning function	Integration of functions to dispatch right vehicle to any incident or medical requirement to get the patient the right care at the right facility.
CC	Improve patient experience through ensuring that staff are effectively trained with the right people providing the right care at the right time	
ES	Maintain and improve upon the delivery of excellent results with national Ambulance Quality Indicators	Continue to ensure best practice developments for patients are in place
ES/QP	Develop the staff and services offered in line with the CARe and the enhanced CARe programme	A focus on extending the skills of some staff in order to ensure that the patient does receive the right care in the right place and at the right time. Enhanced CARe is our initiative which equips our senior staff with enhanced clinical assessment skills to facilitate delivering all necessary care to the patient sometimes resulting in the need for no further onward referral to another service and/or clinician.
ES/QP	To develop the urgent care pathway to improve care offered to non-emergency patients	Where appropriate, patients following emergency clinical assessment are directed to the appropriate healthcare pathway which is more suitable for their clinical needs than the Emergency Department.
ES	To continuously improve the safety and quality of care we provide through evidencing clinical quality improvements and adoption of strong research and development to enhance knowledge of pre-hospital care.	
ES/QP	Work with the acute trusts to reduce the impact of hospital handover delays. In order to ensure a positive, safe patient experience and prevent adverse effects on clinical outcomes due to delays to further hospital assessment and treatment.	As per 'Everyone Counts: Planning for Patients 2013/14' (DH, 2012) - "All handovers between an ambulance and A&E Department must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes; with a contractual fine for all delays over 30 minutes, in both situations, and a further fine for delays over an hour, in both situations."
QP	Continue to implement the A&E review to achieve the most efficient use of our resources , achieving locally commissioned response targets and our two national targets on a quarterly basis through 2013/14	There is a requirement for consideration of decision support mechanisms for staff, either electronic or based upon clinical parameters to support clinical decisions for frontline staff .

KEY
CC - Contact Centre
CD - Commercial Development
CS - Commercial Services
ES - Emergency Services
PTS - Patient Transport Service
QP - Quality and Patient

It is felt that the Objective provides sufficient details without the need for further information to be provided

QP/Workforce	Develop effective clinical and quality leadership that is fit for purpose and is visible to frontline staff through positive improvement in services delivered to patients.	The clinical directorate needs to ensure that it has a structure fit for purpose and can be visible and relevant to frontline staff both in terms of the way it communicates and the way that it responds to everyday clinical challenges.
QP/CC	Maximise the use of hear and treat provision to offer and agree use of a wider range of care pathways for patients, where this is appropriate.	As the demand on unscheduled care services increases we will see increased development of Hear and Treat services (telephone based clinical advice and support) to manage patient care in an alternative way.
QP	Explore with commissioners a system and structure which supports implementation of individual treatment plans and new pathway developments	There is an increasing requirement to respond to individual patient needs i.e. Individual Treatment Plans (ITP's). These can be in relation to individual and or specific patient groups. These ITP's require an integrated system with robust governance arrangements in order to ensure quality and safety.
QP	Work proactively with stakeholders to deliver support, both medical and social to high intensity users to ensure that they get the most appropriate response in the most appropriate place to meet their, often complex, needs.	High Intensity users rely heavily on resources that could otherwise have been delivering an emergency response to those in greater need but also they represent an ineffective use of health resources, particularly where ambulance attendance is linked to hospital attendance. Further the high attendance may indicate a crucial unmet health need for the individual which needs addressing by the wider health and social care community.
Communication	Continue to engage with external stakeholders, to assess the satisfaction of patients and public in the service NEAS provides to deliver at least minimum standards stated in planning guidance.	

HEALTH SCRUTINY FORUM

7 February 2013

Report of: Scrutiny Support Officer

Subject: THE EXECUTIVE'S FORWARD PLAN

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1. PURPOSE OF REPORT

1.1 To provide the opportunity for the Health Scrutiny Forum to consider whether any item within the Executive's Forward Plan should be considered by this Forum.

2. BACKGROUND INFORMATION

2.1 One of the main duties of Scrutiny is to hold the Executive to account by considering the forthcoming decisions of the Executive (as outlined in the Executive's Forward Plan) and to decide whether value can be added to the decision by the Scrutiny process in advance of the decision being made.

2.2 This would not negate Non-Executive Members ability to call-in a decision after it has been made.

2.3 As Members will be aware, the Scrutiny Co-ordinating Committee has delegated powers to manage the work of Scrutiny, as it thinks fit, and if appropriate can exercise or delegate to individual Scrutiny Forums. Consequently, Scrutiny Co-ordinating Committee monitors the Executive's Forward Plan and delegates decisions to individual Forums where it feels appropriate.

2.4 In addition to this, the key decisions contained within the Executive's Forward Plan (February 2013 – May 2013) relating to the Health Scrutiny Forum are shown below for Members consideration:-

DECISION REFERENCE: CE46/11 – Review of Community Involvement & Engagement (Including LSP Review): Update on decisions taken 'in principle'

Nature of the decision

Key Decision - Test (ii) applies

Background

Following a review Cabinet has agreed the future approach of the Local Authority to community and stakeholder involvement and engagement and the Local Strategic Partnership, including theme partnerships at their meeting on 18th July 2011. This was previously in the Forward Plan as decision reference CE43/11.

At the end of June the Government responded to the NHS Future Forum report. In their response they outlined that as the statutory Health and Wellbeing Board "discharges executive functions of local authorities'" it should operate as equivalent executive bodies do in local government. At the time of Cabinet agreeing the future approach it was unclear exactly what this meant and the implications that this would have on the structure proposed. In response some decisions were requested to be made 'in principle' and that these would be confirmed once guidance was issued on the implementation of the statutory Health and Wellbeing Board.

At their meeting on 15th August 2011 Cabinet agreed for a shadow Health and Wellbeing Board to be established by the end of September 2011. This shadow Board will develop into the statutory Health and Wellbeing Board which is expected to be established by April 2013.

The Health and Social Care Bill, which sets out the statutory requirement to introduce a Health and Wellbeing Board, has now completed its passage through Parliament. It received Royal Assent on 27th March 2012 and has now become an Act of Parliament i.e. the proposals of the Bill have become law. Consultation on the Secondary Legislation which will set out the technical regulations for Health & Wellbeing Boards closed on 29th June 2012. The publication of Statutory Guidance on Health and Wellbeing Boards was therefore expected to follow shortly after however it has still not been produced.

The 'in principle' decisions related to the structure of community involvement and engagement and the development of a Strategic Partners Group and its membership. It is these decisions that are the subject of this Forward Plan entry. They will be confirmed or reviewed dependent upon the structure and role of the statutory Health and Wellbeing Board.

Who will make the decision?

The decision will be made by Cabinet however some elements will require Council agreement for changes to the Constitution.

Ward(s) affected

The proposals will affect all wards within the Borough.

Timing of the decision

At the Cabinet meeting on 18th July 2011 it was agreed that a further report would be brought to Cabinet once the statutory Health & Wellbeing Board guidance had been

issued. If the 'in principle' decisions that Cabinet have taken are unaffected then they will be agreed for implementation. If those 'in principle' decisions are affected then Cabinet will be asked to consider alternative proposals which reflect the new position. As we are still awaiting the guidance the detailed timescales for this are currently unclear and may be subject to change. It is expected that a report will be taken to Cabinet in April following agreement of the structure and role of the statutory Health & Wellbeing Board.

Who will be consulted and how?

Cabinet will be asked to consider the implications of the statutory Health and Wellbeing Board on the 'in principle' decisions relating to the structure of community involvement and engagement and the development of a Strategic Partners Group and its membership.

Information to be considered by the decision makers

Cabinet will be presented with detail on the development of the statutory Health and Wellbeing Board and how this will impact, if at all, on the 'in principle' decisions that they made on 18th July 2011.

How to make representation

Representation should be made to:

Andrew Atkin, Assistant Chief Executive, Civic Centre, Hartlepool TS24 8AY.
Telephone: (01429) 523003.
Email: Andrew.atkin@hartlepool.gov.uk

Catherine Grimwood, Performance & Partnerships Manager, Civic Centre, Hartlepool TS24 8AY.
Telephone: (01429) 284322.
Email: catherine.grimwood@hartlepool.gov.uk

Further Information

Further information can be obtained from Catherine Grimwood, as above.

DECISION REFERENCE: CAS137/12 – HEALTH AND WELLBEING STRATEGY

Key Test Decision (i) and (ii) applies

Nature of the decision

The Health and Social Care Act 2012 requires a Health and Wellbeing Strategy to be produced jointly between the Local Authority and key partners of the Shadow Health and Wellbeing Board.

Who will make the decision?

Cabinet and Council.

Ward(s) affected

All Wards

Timing of the decision

The decision will be made in February 2013.

Who will be consulted and how?

There is a comprehensive consultation process with local people and partners as part of developing the Strategy.

Information to be considered by the decision makers

The Draft Health and Wellbeing Strategy which was approved by Cabinet in October 2012.

How to make representation

Representations should be made to Louise Wallace, Director of Public Health, Civic Centre, Victoria Road, Hartlepool, TS24 8AY. Telephone 01429 284030, e-mail: louise.wallace@hartlepool.gov.uk

Further information

Further information can be sought by contacting Louise Wallace as above

DECISION REFERENCE: CAS138/12– ESTABLISHMENT OF HEALTH AND WELLBEING BOARD

Key Test Decision (ii) applies

Nature of the decision

To seek approval to establish a Health and Wellbeing Board. The Health and Social Care Act 2012 requires local authorities and key partner agencies to establish a Health and Wellbeing Board. The key functions of this board will be to develop a Joint Strategic Needs Assessment, a Health and Wellbeing Strategy and work collectively to commission services.

Who will make the decision?

The decision will be made by Cabinet

Ward(s) affected

All wards

Timing of the decision

The decision will be made on March 2013

Who will be consulted and how?

Scrutiny, Cabinet and Key partner agencies, including the Clinical Commissioning Group.

Information to be considered by the decision makers

Previous Cabinet paper on Shadow Health and Wellbeing Board August 2011.

How to make representation

Representations should be made to Louise Wallace, Director of Public Health, Civic Centre, Victoria Road, Hartlepool, TS24 8AY. Telephone 01429 284030, e-mail: louise.wallace@hartlepool.gov.uk

Further information

Further information can be sought by contacting Louise Wallace as above.

DECISION REFERENCE: CAS002/13 – ADULT SUBSTANCE MISUSE TREATMENT PLANS 2013/14

Key Test Decision (i) and (ii) applies

Nature of the decision

To confirm support for the adult drug and alcohol plans in Hartlepool during 2013/14.

Who will make the decision?

The decision will be made by Cabinet

Ward(s) affected

All wards will be affected

Timing of the decision

The decision will be made on March 18th 2013

Who will be consulted and how?

Consultation and planning will be coordinated by the Public Health drug and alcohol team led by the Safer Hartlepool Partnership Substance Misuse Strategy Group that

includes stakeholders such as NHS Hartlepool, Police, the Probation service, and Hartlepool Borough Council departments. The substance misuse plans will be informed by a national determined framework of needs assessment that is conducted November 2012 through to January 2013 using a range of questionnaires, focus groups and workshops with service users and families. Alongside this there is an analysis of local drug and alcohol treatment data and performance to determine areas for improvement and development against national best practice. The views of the local Clinical Commissioning Group and Health and Well being Board will also be reflected within the Plans.

Information to be considered by the decision makers

The report will highlight the findings drawn from the needs assessment; illustrate the strategic priorities for substance misuse treatment from national strategies and guidance; and detail improvements and action across a number of domains to ensure effective drug and alcohol treatment and recovery support. The plans will also indicate targets and performance indicators and confirm financial investment from the Department of Health allocations.

How to make representations

Representations should be made to Louise Wallace, Director of Public Health, Civic Centre, Victoria Road, Hartlepool, TS24 8AY. Telephone 01429 284030 e-mail: Louise Wallacet@hartlepool.gov.uk

Further information

Further information can be sought by contacting Chris Hart, Drug and Alcohol Manager, Hartlepool Borough Council, Level4, Civic Centre, Hartlepool, TS24 8AY. Tel: 01429 284301, e-mail chris.hart@hartlepool.gov.uk

2.5 A summary of all key decisions is attached overleaf:-

TIMETABLE OF KEY DECISIONS

Decisions are shown on the timetable at the earliest date at which they may be expected to be made.

1. DECISIONS EXPECTED TO BE MADE IN FEBRUARY 2013

CE 54/12 (page 11)	Local Welfare Support / Social Fund Localisation	Cabinet/Council
CE55/12 (page 13)	Senior Officer Structure	Cabinet
CAS106/11 (page 15)	Priority Schools Building Programme	Cabinet
CAS137/12 (page 21)	Health and Wellbeing Strategy	Cabinet/Council
RN13/09 (page 32)	Disposal of Surplus Assets	Cabinet / Portfolio Holder
RN74/11 (page 34)	Former Leathers Chemical Site	Cabinet
RN89/11 (page 35)	Former Brierton School Site	Cabinet / Council /

		Portfolio Holder
RN90/11 (page 37)	Mill House Site Development and Victoria Park	Cabinet / Council
RN98/11 (page 39)	Acquisition of Assets	Cabinet / Portfolio Holder / Council
RN99/11 (page 41)	Community Infrastructure Levy	Cabinet
RN5/12 (page 43)	Seaton Carew Development Sites – Results of Joint Working Arrangement with preferred developer	Cabinet
RN20/12 (page 51)	Selective Licensing	Cabinet
RN22/12 (page 53)	Choice Based Lettings Policy Review 2012	Cabinet
RN 27/12 (page 55)	Coastal Communities Fund Round 2 Application	Portfolio Holder
RN31/12 (page 57)	City Deal	Cabinet / Council
RN33/12 (page 59)	High Street Innovation Fund	Portfolio Holder
RN34/12 (page 61)	Adoption of the Review of the Long Term Coastal Management Strategy Covering the Frontage from Crimdon to Newburn Bridge	Cabinet / Council
RN35/12 (page 63)	European Commission 'Youth Guarantee Scheme'	Cabinet
RN39/12 (page 65)	Town Wall Coastal Works: Construction of Set-back Flood Defence Wall and Associated Works	Cabinet
RN40/12 (page 67)	Review of Concessionary Fare Payments to Bus Operators for 2013-2014	Cabinet
RN04/13 (page 73)	The Council's Report on the Home Energy Conservation Act	Cabinet

2. DECISIONS EXPECTED TO BE MADE IN MARCH 2013

CAS138/12 (page 22)	Establishment of Health and Wellbeing Board	Cabinet
CAS139/12 (page 23)	Provision for Pupils with Moderate Learning Difficulties	Portfolio Holder
CAS002/13 (page 25)	Adult Substance Misuse Treatment Plans 2013/14	Cabinet
RN10/12 (page 45)	Acquisition of the Longscar Building, Seaton Carew	Cabinet
RN11/12 (page 47)	Public Lighting Strategy	Portfolio Holder
RN18/12 (page 59)	Leasing of Land to a Wind Turbine Developer for the Erection of Wind Turbines on Land at Brenda Road	Cabinet
RN03/13 (page71)	Additonal Local Highways Maintenance Funding 2013/14	Portfolio Holder

3. DECISIONS EXPECTED TO BE MADE IN APRIL 2013

CAS129/12 (page 17)	Collaboration in Child and Adult Services	Cabinet/Council
CAS136/12 (page 19)	Updated Child Poverty Strategy and Action Plan	Cabinet
RN02/13 (page 69)	Hartlepool Housing Strategy End of Year (2012-2013) Report and Action Plan Refresh	Cabinet

4. DECISIONS EXPECTED TO BE MADE IN MAY 2013

CE46/11 (page 8)	Review of Community Involvement & Engagement (including LSP Review): Update on Decisions Taken 'in Principle'	Cabinet

2.6 Copies of the Executive's Forward Plan will be available at the meeting and are also available on request from the Scrutiny Team (01429 5236437) prior to the meeting.

3. RECOMMENDATIONS

3.1 It is recommended that the Health Scrutiny Forum:-

(a) considers the Executive's Forward Plan; and

(b) decides whether there are any items where value can be added to the decision by the Health Scrutiny Forum in advance of the decision being made.

CONTACT OFFICER – Laura Stones – Scrutiny Support Officer
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Hartlepool Borough Council
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BACKGROUND PAPERS

The following background paper was used in preparation of this report:

(a) The Forward Plan – (February 2013 – May 2013)

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

10 December 2012

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Dr Paul Pagni, Clinical Commissioning Group - In the Chair

Statutory Members

Councillor John Lauderdale (Adult and Public Health Services Portfolio Holder).
Dave Stubbs, Chief Executive
Louise Wallace, Director of Public Health
Ali Wilson, Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group

Non Statutory Members: -

Denise Ogden, Director Regeneration and Neighbourhoods
Martin Barkley, Chief Executive, Tees Esk and Wear Valley NHS Foundation Trust
Christopher Akers-Belcher, Hartlepool LINK Co-ordinator
Margaret Wrenn, Hartlepool LINK

In attendance as substitutes:-

Rod Macleod as substitute for Nicola Fairless, North East Ambulance Service
Ian McHugh as substitute for David Turton, Cleveland Fire Authority

Also Present:

Ian Parker, NHS North

Officers:

Kate Watson, Health Improvement and BHF Project
Chris Briddon, Public Health, BHF Nurse Practitioner
Danielle Swainston, Head of Access and Strategic Planning
Catherine Grimwood, Performance and Partnerships Manager
Denise Wimpenny, Democratic Services Team

110. Apologies for Absence

The Mayor, Stuart Drummond, Councillor Paul Thompson, Finance and Corporate Services Portfolio Holder, Councillor Cath Hill, Children's and Community Services Portfolio Holder, Jill Harrison, Assistant Director, Child and Adult Services, Alan Foster, Chief Executive, North Tees and Hartlepool NHS Foundation Trust.

111. Declarations of interest by Members

None

112. Minutes of the meeting held on 26 October 2012

Confirmed

113. Matters Arising from the Minutes

In relation to Minute 108, the Director of Public Health advised that there had been some useful media interest in relation to the Cold Kills presentation with the town's MP commenting on this issue.

114. Health and Wellbeing Strategy – Verbal Update by Director of Public Health

The Director of Public Health referred to discussions at earlier meetings in relation to the first draft of the strategy and stated that arrangements had been made for further consultation to take place with relevant parties prior to agreement of the final draft which was scheduled for consideration at the next meeting of the Shadow Board.

The Performance and Partnerships Manager referred the Shadow Board to the outcomes document, a copy of which had been circulated and highlighted that the second draft of the strategy would include additional objectives and revisions. An action plan had also been developed to sit alongside the strategy.

The Hartlepool LINK Co-ordinator raised concerns regarding the clarity of future communication arrangements and how various groups, for example, the Old People's Group would feed into the Health and Wellbeing Board. The importance of clear communication links between the Health and Wellbeing Board and CCG was also emphasised. In light of the future governance changes facing the Council , reference was made to the pending cessation of the Children's Services Scrutiny Forum and the need for early consideration of how input from children and young people would

be facilitated. The Shadow Board was advised that work had commenced in this regard and formal agreement was required to determine what groups would go forward in the context of the pending governance changes affecting the authority.

Decision

The update was noted.

115. Public Health Outcomes Framework

The Director of Public Health reported that a link had been circulated in relation to the public health outcomes framework. It was intended that colleagues from the four local authorities across tees valley would meet in January to discuss NHS transitional closedown arrangements, current systems including the most appropriate methods of gathering and capturing NHS data to ensure local authorities were able to access information under the new arrangements. An update on progress would be submitted to a future meeting of the Shadow Board.

Decision

The information given was noted.

116. Regional Support by ANEC – Verbal Update by Director of Public Health

The Director of Public Health sought nominations from the Shadow Board following invitations received from ANEC to participate in a North East Simulation Event to share thoughts on the move from shadow to formal arrangements. Nominations were received from Ali Wilson, Christopher Akers-Belcher, Louise Wallace and Denise Ogden. It was noted that the Director of Public Health would distribute relevant information following the meeting.

Decision

The update and above nominations were noted.

117. NHS Reform Update – Verbal Update by Director of Public Health and Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group

The Chief Officer, Hartlepool and Stockton on Tees Clinical Commissioning Group provided a verbal update on NHS Reform. The appointment of the

Governing Body Nurse had been delayed as a result of the requirement to undertake a formal HR process, details of which were provided. It was envisaged that the post would be filled prior to implementation of the new arrangements. It was highlighted that under the new arrangements work would be managed via an external body and extensive work was ongoing to ensure a seamless transition process.

In terms of key issues, information was still awaited in relation to confirmation of the financial allocation which was expected shortly. It was difficult to develop commissioning intentions until resource information was confirmed. Details of proposed changes relating to access to funding were outlined as well the challenges ahead in terms of managing finances. The importance of effective partnership working to maximise resources was emphasised. Public engagement events were scheduled for January to assist with shaping of commissioning intentions and would focus on achievements during the shadow arrangements as well as future priorities.

The Chair welcomed Mr Ian Parker to the meeting. Mr Parker reported that his main role was to assist relationships between the NHS and local government in preparation for the transfer of powers for public health from the NHS to local authorities. The key areas of support included system leadership, communication, prevention and integration, performance and managing risk.

It was reported that that Mr Parker chaired the North East Health and Wellbeing Board Workstream meetings where lead officers shared best practice as well as attended the North East Health and Wellbeing Board's chair's meetings. The Shadow Board was pleased to receive feedback that the North East, as an area, was progressing the transition very well.

Decision

The update was noted.

118. British Heart Foundation Update *(Public Health Team)*

Representatives from the Public Health Team, who were in attendance at the meeting, delivered a detailed and comprehensive presentation on a healthy lives project and focussed on the following:-

- British Heart Foundation funded project for 3 years
- Project for children and young people aged 7-14 years old
- Empower children and young people to make healthier lifestyle choices
- Take information home to inform parents and grandparents of risk factors associated with cardiovascular disease
- Overall aim to reduce childhood obesity – heart health, healthy eating,

physical activity and smoking

- What Hearty Lives Can Officer
  - heart health
  - workshops/assemblies
  - parents/carers events
  - school staff health
  - training

- Project officially launched on 4 October
  - key partners invited
  - 3 schools showcasing heart health work

Following the conclusion of the presentation, the Shadow Board received a Dvd of a performance by West Park Primary School, one of the schools involved in promoting the project, and an information pack in relation to the project was also circulated at the meeting.

In the discussion that followed, the Shadow Board commented on issues which had been raised in the presentation including the benefits of the external funding, the various approaches to tackling childhood obesity and promoting healthier lifestyles as well as the future health implications of obesity issues.

In response to the Chair's request for clarification as to when statistics would be available on the outcome of the project, it was reported that the aim was to target the 7 to 14 age group as only a small percentage in that age group took part in physical activity. It was envisaged that improvements may be evident by year 3. With regard to evaluation of the project, work was currently ongoing with Teesside University and questionnaires would be circulated to schools. An evaluation report would be produced by Teesside University which would outline outcomes achieved.

In relation to school meals, the Board went on the discuss the importance of targeting schools to ensure healthy choices were promoted and available. The various aims of the project were also discussed including the need to promote healthier lifestyles with parents as well as children and young people.

Decision

The update was noted.

119. Child Poverty Presentation *(Head of Access and Strategic Planning)*

The Board received a detailed and comprehensive presentation by the Head of Access and Strategic Planning in relation to Child Poverty. The presentation focussed on the following issues:-

- Definition of poverty

- Trends in those most likely to suffer - teenage parents, lone parents, families with multiple children, unemployed

- Consequences of poverty
  - cycle of worklessness, low educational attainment, reduced prosperity
  - estimated that child poverty costs the UK almost £40 billion a year
  - research shows that children exposed to poverty, hardship and deprivation are most likely to suffer poverty in later life

- National Context
  - previous Government set target to end child poverty by 2020
  - missed interim target for 2010 to halve child poverty by 2010

- Child Poverty Act
  - all parties signed up to Child Poverty Act 2010
  - commits all UK governments to end Child Poverty by 2020
  - transformed from a target to a binding legal duty

- Local Authority duties
  - co-operation with partners to reduce child poverty in local area
  - prepare and publish "local child poverty needs assessment"
  - prepare a joint child poverty strategy for local area

- Local context
  91,985 population of Hartlepool
  18,270 children and young people aged 0-15 years
  6,180 children/young people living in income deprived families
  33.7% of people claiming an out of work benefit
  30.02% of children in families receiving a key benefit
  25.2% of children receiving a free school meal
  27.7% of household with no one working
  11.8% lone parent households
  34% of children living in poverty

- Welfare Reform Bill
  - Partial abolition of the social fund
  - Council Tax benefit abolished and localised
  - The benefit cap
  - Reductions in housing benefit and restrictions (under occupation)]

- Stricter benefit criteria and changes to rules
- Universal credit

- Child Poverty to rise

- What does this mean to families in Hartlepool

- How are we tackling this?

Following the conclusion of the presentation, a Dvd was presented to the Forum which had been produced in the north east by a group of young people and focussed on child poverty problems. A number of themes had emerged from analysis of the photographs included in the Dvd which included, housing, environment, places to go, family and friends, shops, transport, entertainment, money, crime and anti-social behaviour.

Members expressed concern regarding the level of child poverty nationally as well as regionally and the potential reasons for such levels were debated. The Board recognised that the issue of inequality was a contributory factor. In relation to education attainment levels, whilst it was acknowledged that great strides had been made in this regard, disappointment was expressed that the gap continued to grow between children in receipt of free school meals and their peers. Following further discussion in relation to this issue, the Board emphasised the importance of focussing priorities and support to “at risk” families.

Decision

That the contents of the presentation and comments of Members be noted.

120. Hartlepool Health Status Presentation *(Director of Public Health)*

The Director of Public Health provided a comprehensive presentation on the health profile for Hartlepool. Whilst the health of people in Hartlepool was generally worse than the England average, improvements had been achieved in the last 5 years in relation to life expectancy. There had been significant improvements over the last 5 years in relation to heart disease and stroke related deaths. With regard to cancer related early deaths, the trend over the last 5 years had shown no real improvement nor a significant increase.

In terms of teenage pregnancy, there had been significant improvement over the last 10 years. The under 18 conception rate for Hartlepool in 2009 was 57.3 per 1000 and was a 24.3% reduction on the baseline rate of 74.8 in 1998. In 2009 37% of conceptions led to an abortion, this compared to 46% of conceptions which led to an abortion in 2008.

Data in relation to alcohol specific admission rates by age was provided.

Male admissions were generally twice as high as females in most age groups. Peak admissions from males and females were in the age range 30 to 55. The evidence suggested that in addition to continuing with efforts to prevent the acute effects of alcohol misuse amongst younger people there was also a need to address the chronic effects of excess alcohol consumption amongst middle-aged people.
Members were advised that whilst there had been significant improvements over the last 5 years in relation to adult smoking rates, prevalence in some wards was still in the region of 50 to 60%. Smoking in pregnancy rates had seen a significant improvement. However, further work was needed to continue this trend, focussing especially on smokers from disadvantaged groups.

With a view to tackling the increasing rise in adult obesity, it was noted that a number of initiatives had been introduced to address this issue.

Decision

The presentation and comments of Members were noted.

121. Future Agenda Items

In terms of the future of the Shadow Board, given the pending changes to the governance arrangements, it was agreed that this be included in the work programme of the Shadow Board and considered at an early meeting in January 2013.

The meeting concluded at 11.50 am.

CHAIR

ITEM 4

TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE
7th January, 2013

PRESENT:-

Representing Darlington Borough Council:
Councillors Newall (in the Chair) H. Scott and J. Taylor.

Representing Hartlepool Borough Council:
Councillors Fisher and Hall.

Representing Middlesbrough Council:
Councillor Junier (as substitute for Councillor Dryden).

Representing Redcar and Cleveland Borough Council:
Councillors Carling and Kay.

Representing Stockton-On-Tees Borough Council:
Councillors Wilburn and Mrs M. Womphrey.

Present as an observer: Councillor Skilbeck, Hambleton District Council.

APOLOGIES – Councillor S. Akers - Belcher (Hartlepool Borough Council), Councillor Cole, Dryden and Mrs Pearson (Middlesbrough Council), Councillor Mrs Wall (Redcar and Cleveland Borough Council) and Councillor Javed (Stockton-On-Tees Borough Council).

OFFICERS IN ATTENDANCE – A. Metcalfe (Darlington Borough Council), L. Stones (Hartlepool Borough Council), J. Ord (Middlesbrough), M. Ameen (Redcar and Cleveland Council) and P. Mennear (Stockton-On-Tees Borough Council).

EXTERNAL REPRESENTATIVES –

Darlington Clinical Commissioning Group – Martin Phillips, Chief Officer (Designate);
Hartlepool and Stockton-On-Tees Clinical Commissioning Group – Ali Wilson, Chief Officer (Designate);
South Tees Clinical Commissioning Group – Amanda Hume, Chief Officer (Designate) and
Tees, Esk and Wear Valleys NHS Foundation Trust – David Brown, Director of Operations – Tees.

28. DECLARATIONS OF INTEREST – There were no declarations of interest reported at the meeting.

29. NOTES – Submitted – The Notes (previously circulated) of the informal meeting of the Tees Valley Health Scrutiny Joint Committee held on 3rd December 2012.

AGREED – That the notes of the meetings be approved and the decisions be confirmed.

30. OVERVIEW OF THE TEES VALLEY CLINICAL COMMISSIOINING GROUPS (CCG) – Following a request from Members, Chief Officer (Designates) from the three Clinical Commissioning Groups (CCGs) across the Tees Valley were present at the meeting to provide an overview of the status of the individual CCGs and Members were particularly interested to note the outcome of the Authorisation process.

(A) SOUTH TEES CCG – The Chief Officer (Designate) submitted a presentation (previously circulated) outlining the South Tees CCG and provided an overview of the CCGs vision. The plan of improving health together was outlined and the successes to date were shared. Members were pleased that the CCG plan to continue with the reform agenda and to focus more on prevention, integration e.g. IMPROVE (Integrated Management and PROactive care for the Vulnerable and Elderly), delivering financial efficiencies to enable investment on priorities against a challenging financial context and welfare reform, continuing to drive up quality and develop the organisation.

Mrs Hume reported that the CCG are building relationships with Hambleton and Richmondshire CCG as well as working particularly closely with Hartlepool and Stockton CCG. Members were pleased to note that the CCG went through the formal authorisation process in October 2012 and have been working towards addressing the only outstanding issue which was the appointment of the Executive Nurse. Copies of the Clear and Credible Plan 2012 -2017 were tabled at the meeting.

(B) DARLINGTON CCG – The Chief Officer (Designate) submitted a presentation (tabled at the meeting) which tracked how the CCG intend to work together to improve the health and well-being for the people of Darlington. Mr Phillips reported that the Darlington CCG has focused on building relationships and making health everyone's business to ensure that the CCG are not working in a silo. Darlington has a reputation for working in partnership to deliver services and Darlington has for many years worked as one big GP Practice and would continue to do so. He reported that leading clinicians have developed relationships with secondary care and are in the process of organising a Clinical Summit.

The CCG are keen to ensure that the patient/public voice is well represented and are advocating patients as good assets to the CCG. It was explained that the CCG has recently reduced the number of Governing Body members and that two Primary Groups have been formed to include GP membership considering Quality and Innovation and Finance. It was noted that Darlington CCG were also yet to appoint an Executive Nurse.

(C) HARTLEPOOL AND STOCKTON CCG – The Chief Officer (Designate) submitted a presentation (tabled at the meeting) outlining the Hartlepool and Stockton CCG and provided an overview of the CCGs health challenges. The plan of reducing inequalities and improving well-being was also outlined, together with improving quality and safeguarding. Mrs Wilson explained that Hartlepool and Stockton CCG were sharing the appointment of the Executive Nurse with the South Tees CCG with a strong focus on quality and safe guarding. Both CCGs would continue to work extremely closely to together to learn from each other and share services, where possible and appropriate. It was noted that during the shadow year patients/public had submitted their views and feedback to the CCG and a number of open meetings had be held, this would continue

in the future. Relationships with the local LINks had also been positive and it was hoped to continue with Healthwatch in the coming months.

Mrs Wilson reported similar challenges to the other CCGs and discussed how the financial sustainability would be managed up to 2016. It was noted that the Quality Premium Payment would be paid accordingly to achievements against the stretch targets which were yet to be agreed by the Health and Well Being Board. Members were pleased to note that some of the QIPP savings made over the past two years has been invested into carer services to support family and preventing people from being admitted into hospital, however, it was noted that without continued efficiencies through QIPP, significant additional investment in services would not be sustainable.

General discussion ensued about engaging with patients and public and how much awareness they have of the changes in health; prevention services and commissioning practices; funding panels and concerns about flexibility and concerns about finance constraints.

Particular reference was made to how the CCG intend to work differently and how partnerships are key to jointly delivering services. Members were reassured that CCGs would use their budget allocation wisely and not withdraw services but assess the value and look how services can be delivered differently, most efficiently and effectively. The relationship between the CCG and Local Authority is a key one and if services were to change communications must be carried out in partnership with the Local Authority to ensure the general public are kept fully informed.

Members welcomed self-management of conditions but acknowledged that there is a culture change required to enable the public to feel confident to do so and proactively manage their conditions with their GPs. Early intervention was also highlighted to invest in people's well-being to ultimately reduce costs later in life and enable conditions to be managed safely throughout a patient's life.

AGREED – (a) That the updates and information be noted.

(b) That all the Officers be thanked for the attendance

31. OVERVIEW OF TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST – The Director of Operations – Tees, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) submitted a presentation (previously circulated) which reported on three areas as followed; rehabilitation beds, organic and functional wards for older people and Primary Care Psychological Therapy Services and Any Qualified Provider. The Director outlined the changes to the number of rehabilitation beds across Teesside and explained that there was also the ability to spot purchase packages or beds from other providers as well as TEWV. He reported that a recovery liaison worker role had been developed and was in place on acute wards, that bed management meetings are taking place weekly to co-ordinate all beds in rehabilitation services and waiting times was the next target.

The Director highlighted that there had been a number of service development in respect of mental health services for older people and as a result there has been an impact on the number of organic beds (due to reduced admission numbers and length and feedback from stakeholders.

Specific reference was made to the need for change in Hartlepool and the need for reconfiguration. The principles of proposals were that organic and functional inpatient beds should be separate to ensure absolute focus on differing needs and care requirements; inpatient care should be exceptional rather than the norm, and for as short duration as clinically appropriate and where possible achieve male and female separation within ward areas. The Director explained that those with functional and organic conditions who required inpatient admission should not be expected to share inpatient facilities. There is an underutilisation of specialised services at Westerdale South and Picktree and that clinically the proposal to only have functional patients at Wingfield represented the best solution to improve services for patient in the Hartlepool and South Easington areas. This was agreed by Hartlepool Borough Council's Health Scrutiny Forum on 29th November 2012.

With regards to improving Access to Psychological Therapies (IAPT) and Primary Care Psychological Therapy Services (PCPTS) and the Director explained that TEWV was one of five providers of this service. The service outline was to provide a comprehensive, PCPTS in line with national guidelines and clinical best practice for adults within the Tees area. The specification for access includes referrals, waiting times, location of service delivery and operating times. Outcomes and tariffs were explained and Members were shocked to hear the payments for a successful and unsuccessful treatment.

The outcome of Rapid Process Improvement Workshops has found that referral to treatment should include an assessment offered immediately or at a convenient time, that 95% move to treatment and telephone assessment or face to face if preferred and treatment to discharge. This would make the model of care work but the Trust are aware that they do not have the correct staffing mix and recognise the need for training and promotion in the first year. Proper costing of premise and telephony would need to be carried out as well as management of overheads and timescales for the shifts in modelling would be very ambitious.

AGREED – (a) That the updates be noted.

(b) That the Director be thanked for his attendance at the meeting.

(c) That further update be requested in respect of Any Qualified Provider, Payment By Results and Enhanced Liaison in due course.